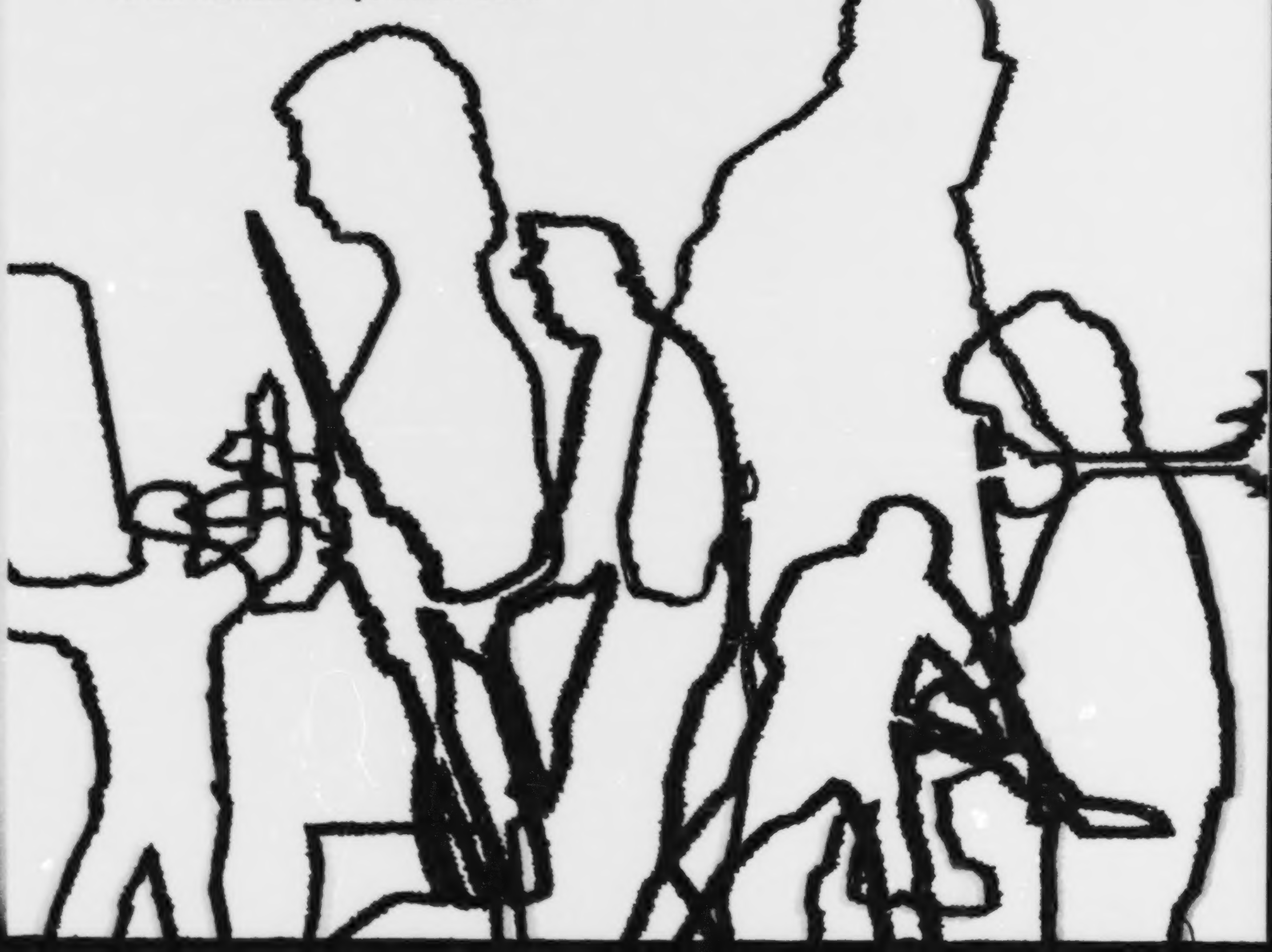
Ontario

# "an injury [redacted] to one is an injury to all"

## A Summary of the Report of the Ontario Task Force on the Vocational Rehabilitation Services of the Workers' Compensation Board



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**Erratum**

A typographical error occurs on page 52, paragraph 5, line 1. The second word, "employees" should be "employers".

# AN INJURY TO ONE
# IS AN INJURY TO ALL

## Towards Dignity and
## Independence
## For the Injured Worker

**A summary of a report submitted**
**to the Minister of Labour on September 2, 1987**

**Ontario Task Force on Vocational Rehabilitation**

Ontario

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# The Injured Worker

According to the Ontario Federation of Labour, every six seconds of every working day a Canadian worker is injured. Every 12.7 seconds, a Canadian worker suffers a permanent disability. Every two hours one dies. Overall, Ontario statistics reflect a national trend of increases in numbers of disabling injuries which have far exceeded the growth of the work-force. According to a study of accident rates in the U.S. and Canada, these figures clearly demonstrate a rapidly deteriorating state of affairs in matters of work safety, despite the promises of the Occupational Health and Safety Act.

In 1985, 426,880 claims were reported across Ontario, an increase of 9.8% over 1984, with a corresponding 9.6% increase in serious injuries resulting in lost time. Most alarming perhaps is the marked increased in the proportion of high-percentage (50.1 - 99.9% disabled) permanent disability assessments to total awards over the past six years. (In 1985, awards in this category accounted for 34% of total awards granted, compared to 17% in 1981.) Preliminary figures for 1986 offer little hope for a reversal of this trend: total claims rose by 4% and lost-time injuries by 7.9% over the same time period in 1985.

The phenomenal rise in serious lost-time injuries and substantial number of pension awards point to a large pool of workers for whom a smooth reintegration into the workforce is impossible. Many of these workers could benefit greatly from timely access to vocational rehabilitation services. Unfortunately, the WCB assigns a very low priority to rehabilitation allocating a mere 3.3% or $24 million of its 1986 budget for vocational rehabilitation services.

## *Characteristics of VRD Clients*

Many of the workers referred to the Vocational Rehabilitation Division (VRD) embody features most often associated with poor re-employment and rehabilitation outcomes. They are typically males in their mid-40s who have worked in labour-intensive blue-collar jobs. Low educational levels combined with lack of English fluency restrict the workers' ability to understand the intricacies of the WCB bureaucratic machine and result in few transferable job skills, thus limiting alternative employment options.

Many of these workers have back injuries which restrict their ability to bend, lift, walk, sit or perform prolonged or repetitive movements, effectively eliminating any hope of returning to manual labour. The disabilities are often severe, long-term and intractable.

Perhaps the most telling evidence for the severity of injuries sustained by this group is lost-time. Thirty-five percent of the sample were off work following injury for at least three years and the remaining 65% lost an average of 230 workdays. Seventy-four percent experienced a subsequent workplace injury, over half of which were reoccurrences or deteriorations of the original condition.

The employment picture painted by the workers is one in which attempts to return to work are interrupted by periods of relapse and recovery, necessitating reopening of cases with the WCB, further medical treatment, pension reassessments and appeals, seemingly futile attempts to find suitable lighter work and subsequent unemployment. Indeed, according to a Task Force survey, 73% of workers interviewed were not working and nearly 68% were receiving wage-loss benefits from WCB.

In comparison, statistics from the Vocational Rehabilitation Division (VRD) show that fully half of case closures result from the injured worker's re-employment. However the VRD does not keep records of how many injured workers remain employed after six months so unless the worker reapplies for VRD services, he is considered "rehabilitated" regardless of what his actual status is.

Those that do get jobs find their wages substantially reduced. Whereas only 22% of the 1986 closures were making less than $7.20 an hour before their accident, 41% were in this category after rehabilitation. The proportion of workers who had been earning more than $12.00 an hour before injury declined from 38% to 25.5% after rehabilitation. Recognizing the likelihood of a substantial drop in wages pre- to post-injury, WCB provides a wage-loss supplement to employed workers to help make up this difference. The supplement is in principle available for up to three years, during which time the worker is optimistically anticipated to have regained lost financial ground. In practice, however, actual duration of the supplement is discretionary and wage-loss benefits are usually terminated between six and 18 months.

For many workers, these facts spell poverty: 10% report having been on welfare, and a further 82% say their standard of living has decreased. Although many are homeowners, 13% state they have lost a home as a result of injury and subsequent financial problems, and a further 26% indicate continuing uncertainty about living arrangements. Many workers are driven to take extreme measures to save family homes, and grown children, parents and other relatives may share living quarters and expenses to make ends meet.

Prolonged unemployment contributes to a profound sense of worthlessness and hopelessness. Workers describe a pattern of increasing loss of motivation and self-absorption in which they gradually focus on their disabilities rather than their abilities. Concentration on pain replaces constructive problem-solving. Financial and health concerns begin to dominate their outlook, and passivity, learned helplessness and depression become firmly entrenched as they wait for their doctors and counsellors to tell them what to do next. Seemingly endless confrontations with the WCB bureaucracy produce considerable anger and frustration.

Workers describe periods of alcohol and drug abuse, attempted suicide and family violence which they link to financial pressures, mental distress and pain. Most workers report serious deteriorations in their relationships with spouses and children and great disruptions in their social networks. Despite often serious personal problems, however, injured workers rarely request help from the VRD for such matters — and when they do the system does not seem to care.

Statistics from VRD sources and Task Force interviews indicate that typical VRD clients do not come into contact with VRD counsellors for some 18 months following injury. During this lengthy period the workers have been encouraged by medical personnel to think of themselves as "sick" and their only contact with the WCB has been a twice-monthly cheque in the mail. When they are finally deemed to be ready for vocational rehabilitation, they are contacted and interviewed by VRD counsellors who inform them they are now expected to actively conduct a job search or establish some plan of vocational rehabilitation.

This may very likely be the first time since their injury that each has been asked to adopt the role of a healthy person and they are understandably confused, apprehensive and skeptical about the prospect of finding a job. Their counsellors interpret their attitude as a lack of motivation or malingering, and threaten to cut off their benefits if they fail to co-operate in what appears to be a pointless exercise.

For the minority of VRD clients who are deemed "not job ready", the next step in the rehabilitation process is for the counsellor to establish a rehabilitation plan. A wide range of assessment and retraining options is available to the counsellor, but in practice access to these services is largely discretionary and their expense only justified as a last resort.

In particularly intractable cases, for example, workers may be ordered to go to the Downsview Rehabilitation Centre. Uprooted from their family and community, confused, anxious and in pain, they nevertheless co-operate because they hope the doctors there can help them. To their surprise, however, the doctors and therapists are not interested in their problems — they seem only to want to prove that, despite what their specialists say and what they feel, the injured workers are fit for "modified" work and do not deserve further benefits.

Injured workers described to the Task Force the inhumane treatment they received at Downsview. They are forced to stand for hours in lines, to carry their luggage and make their own beds although they can barely walk. Nothing is explained to them; examinations are cursory at best; and the treatments leave them feeling worse rather than better. If they complain or balk at treatment, they are accused of faking the extent of their disability. "It's all in your head," they are told. They know if they are labelled "unco-operative" they will lose their benefits. So they endure their humiliation and suffer in silence.

In a coordinated rehabilitation program, assessment would be the logical first step in determining the course of treatment or training. In reality, the purpose of assessments by Downsview and WCB personnel seems to be to limit entitlement to pensions and benefits and access to further services from the VRD. Often the determination of "fit for light work" is in complete contradiction to the reports of the workers' specialists who have examined them thoroughly and worked closely with them throughout their recovery. Nevertheless, the opinion of WCB medical personnel is invariably the one which decides the workers' fate and often, in the opinion of WCB doctors, the majority are fit for modified work.

Based on this assessment, workers looking for modified work are told to pound the pavement in search of elusive "light duty" jobs. The ideal work for them requires no lifting, bending or twisting, no repetitive movements and no prolonged sitting or standing. Where will 45-year-old disabled workers with less than a high school education find such work? Possibly their counsellor will find them one for minimum wage with a company with a high turnover rate. The workers discover that so-called "light" work is more taxing than their original jobs. In any event, when the "training period" is over and the subsidies to the companies expire, the workers could lose even these marginal jobs.

In desperation they look for jobs on the open market where they are forced to minimize or deny the extent of their disabilities in order to find employment. They take jobs which are now far beyond their physical capabilities, re-injure themselves and once again begin the round of doctors, physiotherapy, pension reviews and VRD counselling.

At some point in this cycle, some workers may decide they have had enough. Although the compensation system was designed to eliminate the need for costly litigation, they discover they can cut through red tape much faster with legal representatives, MPPs or other advocates on their side. They may finally get a chance for some real rehabilitation, perhaps some training or upgrading which can make them more competitive in the employment market.

But the reality is that less than a quarter of clients who go through the VRD will get training and this figure has steadily declined over the past five years. Furthermore, a look at who is granted the rare privilege of training shows that those who need it the most are least likely to receive it. The older, less-educated workers with limited skills and English fluency are told there is no help for them. They must go and find jobs.

Even when injured workers are given the opportunity to participate in training, they lack any real input into decisions concerning their future. Workers who seriously desire retraining or education are denied the opportunity to pursue long-term goals to re-employment. Thrust into hastily considered training which do not suit them physically or temperamentally, workers experience considerable stress because they know failure will mean curtailment of benefits and another ride on the endless compensation merry-go-round.

## *VRD Closures*

In 1986, 41% of VRD cases were closed for a variety of reasons and categorized under the heading "No Further Rehabilitation Action Indicated" (NFRAI). The title would suggest that for some reason, these workers no longer need help. However, excluding those individuals who have recovered or died, fully 33% of VRD closures result from the counsellor's perception that the worker has been unco-operative.

For example, workers may refuse to take jobs that their personal specialists have determined are beyond their physical capacities. They may suffer emotional disabilities which the Board refuses to regard as compensable, decline jobs they find demeaning, or refuse to relocate to take positions.

Workers pay a high price for their perceived non-compliance. First, they remain unemployed. Then they are terminated from the VRD and benefits are either reduced by 50% or totally suspended. Injured workers have the right to appeal this decision if they wish, but this usually means lengthy waits if they have to go before hearings officers and further delays if the claims go to the Workers' Compensation Appeals Tribunal (WCAT). During this period the workers must live on either their meager (10% – 20%) pensions and welfare.

Who are the workers most likely to fall into the NFRAI category? It is clear that they are the ones who are the least competitively employable and therefore most in need of rehabilitation. According to a Task Force study, they are the older, less-educated workers, employed in low-earning jobs prior to injury and now suffering from chronic or degenerative disabilities. They are the most likely individuals to return to the system again and again, who will cost the WCB and society more money in the long run because the system is designed to meet a bottom line, not to help those who need help most.

# The Workers' Compensation Board: Its Philosophy

The *Workers' Compensation Act* was enacted in 1914 to provide a "no-fault" insurance scheme of financial compensation that would save injured workers and employers litigation costs offset by premiums paid by the employers. As long as the premiums were less than the feared legal costs, things ran smoothly.

But since 1914 premium costs have continued to rise rapidly and workers began to realize that, as an insurance scheme, the Act disallowed their suing for suffering and non-debilitating pain. It became apparent that the nature and extent of rehabilitation services were restricted to restoring employability and controlling the costs of running the WCB. Very little rehabilitation was offered that would reconstitute a life, damaged by an accident for which no fault was assessed — a life where functional, social and economic independence may have been lost.

Unfortunately the WCB is still driving the 1914 model of rehabilitation. Concepts of rehabilitation held before the First World War are still prevalent in Ontario despite society's conceptualization of, and attitude towards disabilities, shifting from the impact of the traumatic event towards a better understanding of its effects. There is no disciplinary body that certifies rehabilitation service delivery on the basis of quality and no school training rehabilitation counsellors at the graduate level in Ontario. There is no acceptance of the fact that the disabled are entitled to receive the best treatment the province can afford, whether they can be re-employed or not.

Close scrutiny of the messages unconsciously transmitted by words and deeds shows that the following four principles drive the model practiced today.

## *The First Principle*

> *Rehabilitation services to workers, injured on the job in Ontario, are offered only as a last resort.*

The *Workers' Compensation Act* of Ontario is clearly an insurance scheme whose primary focus is financial compensation. Rehabilitation is treated merely as a supplementary service offered at the board's discretion and directed solely towards re-employment.

Of the 142 sections in the Act. Rehabilitation is relegated to a weak, nine lines of vague indecisiveness in Section 54 reflecting the disinterest of government and society of the early twentieth century. The Act stresses the economic commitment of that government to financial compensation and Acute Health Care and emphasizes that the WCB's purpose is to foster the worker's return to the job at minimal cost. In 1914 this may have been acceptable. However, today most of the western world is concerned with the injured worker, not simply as a cog in an industrial wheel, but as a human being.

At the WCB, rehabilitation is a last resort. As Section 54 states:

*the board may take such measures and make such expenditures as it may deem necessary or expedient.*

This attitude leads to inequality of treatment delivery and vulnerability of the staff to external pressure and internal prejudices. Rehabilitation is offered to injured workers by adjudicators who interpret a set of vague criteria based on grudging acceptance of the need to offer them rehabilitation services.

Even though the Act professes to be a "no-fault" insurance scheme, there is an underlying curr ent that pins guilt on the injured worker for having had the accident and this contributes to the determination of whether rehabilitation services will be offered. The no-fault basis of the workers' compensation system implies that workers are not to blame for their accidents, injuries or disabling conditions but, possibly because of the need to keep costs to a minimum, injured workers are often faulted and therefore seen as undeserving of rehabilitation.

The emphasis on saving money puts pressure on medical personnel and rehabilitation counsellors to severely limit rehabilitation services to the injured workers. It promotes an adversarial relationship between those injured workers who sense they must fight for what they should receive and the WCB staff who are afraid that the injured workers will exploit the system.

This adversarial process results in expensive court costs, repeated referrals to medical personnel for additional opinions, unnecessary vocational and work assessment and frustration and anger on the part of the injured workers. In the long term, the struggle to keep costs down may be far more expensive to the WCB, injured worker and society in general.

## The Second Principle

*The definition of rehabilitation is restricted to medical and vocational rehabilitation.*

Section 54 of the Act states that part of the mission of rehabilitation is

> *to aid in getting injured workers back to work and to assist in lessening or removing any handicap resulting from their injuries.*

Its interpretation is made as narrow as possible, and the service is restricted to a reduction or removal of any functional disablement that will help the injured worker return to work.

In the last decade, the emphasis in rehabilitation has shifted from physical and vocational rehabilitation to the reduction of disadvantages in all areas of life that result from an injury. Yet one of the underlying principles that drive rehabilitation is that it is restricted to medical and vocational areas and is directed solely to the reinstatement of a worker at the job. As long as this continues, the determination of employability will remain the responsibility of medical personnel, one that is not really in their field of expertise and one they are frequently reluctant to accept.

## The Third Principle

*Only job placement is acceptable as a successful outcome of rehabilitation.*

In a society in which the work ethic is dominant, all adults ar expected to work or look actively for a job. Those who don't are considered by that society to be either sick or malingerers.

This tenet seems to be most apparent at the WCB in staff attitudes to workers with invisible injuries. These invisible injuries include physical disablements that are not readily identified by objective methods, such as migraine or lower back pain and psychological/sociological handicaps that result from the emotional trauma of injuries. They must be recognized and treated for their effect on injured workers which can be just as devastating as more visible injuries.

Invisible injuries are made worse by the length of time the condition drags on. Victims suffer from chronic emotional or physical problems that do not heal quickly. The WCB has no program for people suffering from invisible injuries. They are usually pensioned off according to a physical rating schedule sometimes referred to as a "meat chart", based on a fixed value for each part of the body and receive a fraction of their previous income. They are then thrust into the community to live on welfare, family allowance or income from other members of their family.

People who are not compliant and respectful of the system, people who may have psychogenic disabilities or are terrified of making a giant leap back into the work force are callously rejected by the board. It convinces society, including the injured workers themselves, that the responsibility for the accident and difficulties encountered in rehabilitation rest mainly on them.

Because job placement is the only acceptable outcome, rehabilitation counsellors are really vocational counsellors and receive little training in the evaluation of the mental and social impact of a traumatic event. When clients, who are reported by medical rehabilitation to be fit for light, modified work, balk at placement in meaningless jobs or inappropriate work that may lead to re-injury, some counsellors lack the insight to search for both the internal and external barriers that militate against re-employment.

Sometimes WCB staff get injured workers back to work by threatening to cut off their benefits. Time and again injured workers relate tragic stories of how they are cut off benefits because they can't find work on their own. These are workers who had spent years at blue-collar jobs, with families to support. The frustration and humiliation they endure is appalling.

## *The Fourth Principle*

*Paperwork is more important than people work.*

Many organizations become preoccupied with administrative competence to the point where they lose sight of their mission. They become more concerned with reporting functions such as bookkeeping, statistics and annual reports than with the services they were meant to perform.

Human service organizations are especially vulnerable to the paperwork syndrome. The model of an industrial company that produces a large number of identical objects cannot be adapted easily into human services operations. Tracking the size of a caseload, the mileage travelled or the number of telephone calls made per day may make for interesting statistics and reports, but they contribute nothing to the quality of health service delivery.

The translation of this fourth principle into action has a number of results. Clients who are not compliant are rejected. Services that are difficult to organize and deliver are avoided. Clients may not be referred for rehabilitation services until pressure is brought to bear. Staff chafe with a reported 40% of their time spent at paperwork. And follow-up services for clients whose files have been closed are not performed.

The Task Force has concluded that these four principles underlie much of the antagonism and confrontation among the various sectors of society and the Workers' Compensation Board.

# Workers' Compensation and Rehabilitation Board: Its Philosophy

Clearly the principles underlying the present structure and process must be altered if any significant change is to be made. New principles must be established that reflect a more caring attitude towards and empathy for people who are injured on the job or contract an occupation-related disease. The value of human life must be respected and the preservation of an individual's dignity and quality of life must be at the core of our treatment of injured workers in Ontario.

## *Mission*

The Task Force has therefore adopted a mission statement that will guide a model of rehabilitation to reflect these attitudes.

1. The Workers' Compensation and Rehabilitation Board is committed to the concept that workers, injured at the workplace, must have the opportunity to restore their competence to the maximum possible extent in all areas of disability — physical, mental, social, vocational and economic.

2. The Workers' Compensation and Rehabilitation Board recognizes that while re-employment is the primary goal of workers injured at the workplace, this cannot be the only goal, and that Workers' Compensation and Rehabilitation Board must be concerned with independence and stability of the injured worker in all areas of life.

3. The primary objective of the Workers' Compensation and Rehabilitation Board rehabilitation services is to help an injured worker identify specific employment barriers and to explore options to their removal, taking into account the realities of both the injured worker's areas of strength and limitation and the demands of the current, competitive employment market.

   To this end, counselling and assistance in personal adjustment, in appropriate and realistic settings, must be offered, as well as comprehensive vocational evaluation and assessment, training in competitive work habits, skill training, training in job seeking skills and assistance in appropriate job placement.

4. Workers' Compensation and Rehabilitation Board recognizes that the primary purpose of its rehabilitation division is to provide effective services by purchasing community and private services where

appropriate, to achieve the goal of maximum independence in all five areas of rehabilitation.

5. The Workers' Compensation and Rehabilitation Board, through its Rehabilitation Division, is committed to working actively with injured workers, employers in the private and public sectors, organized labour and the community towards the integration into the employment market of injured workers with physical, emotional or social barriers.
6. The Workers' Compensation and Rehabilitation Board, through its Rehabilitation Division, is committed to including the injured worker as an equal partner in formulating rehabilitation goals, identifying programs and developing services.
7. The Workers' Compensation and Rehabilitation Board is committed to assure that adequate rehabilitation facilities are available, run by the community for the injured workers in the province.

## *Structure*

Claims, not rehabilitation, is the driving force behind the WCB today. The power to grant or stop benefits is invested in the same counsellor who offers rehabilitation. This double-edged sword is quite often used as a weapon against the injured worker as the counsellor threatens to cut off benefits if the worker is in any way unco-operative.

In order to provide effective rehabilitation, the functions of claims and rehabilitation must be separated and rehabilitation must be made a full partner in the entire process. The new importance of rehabilitation should be recognized in the title; injured workers and vocational rehabilitation practitioners must be represented on the corporate board; and the organizational structure must give the Vocational Rehabilitation Division the power to carry out its services.

## *The Right to Total Rehabilitation*

The WCRB's goal of rehabilitation will be:

> *to assist workers who have suffered occupational injuries or debilitating diseases linked to the workplace in the process of restoration, to the fullest physical, mental, social, vocational and economic usefulness to the maximum possible extent.*

However, current rehabilitation services focus on medical and vocational services and are offered to injured workers only at the WCB's discretion. The decision is made by claims adjudicators and frequently under pressure from medical personnel, WCB administration, lawyers of the injured workers and others with political influence. The way service delivery is determined is not only demoralizing to those who must make the decisions but destructive to those who receive them.

Rehabilitation is defined in its narrowest sense with the return of the injured worker to the workplace rather than with concern for the worker's dignity. Efficiency becomes more important, but at the same time the bureaucracy becomes top heavy and flow through the system is slow. Counsellors receive double messages. They are instructed to rehabilitate the injured workers but at the same time close cases rapidly and concentrate on paperwork. They are challenged to do their best but are not taught how to do it and more importantly, don't know what the board wants them to do.

Today the primary function of the Vocational Rehabilitation Division is to process injured workers through a system that receives them after they have received medical treatment and returns them to the same job or a similar one. There is little concern with their dignity, their quality of life or that they will continue to fall further behind their co-workers in income.

## *The Problems Faced*

In examining the current rehabilitation process of the VRD, several problems are evident.

1. The system is slow. Things that could be handled at the same time are usually performed consecutively, frequently because no single person takes responsibility for a client.
2. Clients fall through the cracks and don't get the services they need in part because no particular counsellor is responsible for the client and counsellors must fill their quota of closures.
3. With duplication of files and different people located in several offices handling varied aspects of the case, communications becomes a contributing factor to cost and quality of service delivery.
4. Counsellors are hired who have never developed the skills of assessment and intervention and do not understand the demands and requirements of the workplace. Once on the job they do not keep current in their field or develop their counselling skills.
5. Counsellors are given double messages — "supply quality rehabilitation services but keep costs down". While statistics look good, clients are frequently dissatisfied.
6. Often services are unavailable in the local community. The WCB does not invest time, energy and money to help the community develop

them. When the board does offer these services itself, it often does it poorly, as the Review Team that investigated Downsview Rehabilitation Centre discovered.

7. The system favours injured workers with the greatest chance of becoming re-employed — the English-speaking young, well-educated and married clients.
8. The board has developed a number of ineligibility criteria which either limit or restrict access to vocational rehabilitation services.
9. The WCB may also be in conflict with the Human Rights Code so that the application of these ineligibility criteria could have legal consequences.

## *Dignity and Quality of Life Important*

While re-employment is the ultimate goal of rehabilitation, vocational rehabilitation may not be appropriate for everyone. When desired, the injured worker must have the right to receive such services, but this should not be offered at the expense of other forms of rehabilitation. Nor should those, for whom re-employment is impossible, be relegated to the discard bin.

Rehabilitation should be offered in every area that affects an injured worker's life. The quality of life of an injured worker, his or her status within the family and within society, the individual's self-worth, dignity and independence must all be preserved.

While the work ethic is predominant in our society today, over 6% of able-bodied adults in Ontario cannot find meaningful work and there is a much larger group who have give up the struggle to find a job. These people must not be seen as pariahs. Rather they deserve the right to a decent quality of life. This is especially true of those who have incurred a disability at work. The right to rehabilitation must be inscribed in the Act and acknowledged with empathy and understanding in the service delivery system.

## *Hidden Caseload (Retroactivity)*

There are a number of workers who were denied or never received rehabilitation services and have not recovered to the point of being able to return to work. There is no way to identify the extent of this hidden caseload, but it is estimated to be about 12,000 to 18,000 each year.

Many workers have also received inadequate services, especially in light of the extended, holistic definition of rehabilitation. Many are under-employed and poor. The Task Force feels strongly that a case review should be carried out by the Worker's Compensation and Rehabilitation Board offering a full range of rehabilitation services to those who have been inadequately served the first time.

Regardless of the attempt by the Workers' Compensation and Rehabilitation Board to develop comprehensive and co-ordinated rehabilitation services for workers injured on the job and to involve the worker as an equal partner in the process, disputes will probably arise and an appeals procedure must be put into place.

# Case Management

The Task Force recommends the adoption of a case management model of service delivery that assigns a case to a single individual, called a case manager, who bears responsibility for the outcome. The case manager ensures the injured worker receives the services needed to achieve maximum rehabilitation in a co-ordinated, effective and efficient manner.

*Comprehensiveness* and *continuity* of service provision are critical to the process. Working closely with the injured worker, the case manager must make certain that every appropriate rehabilitation service is offered and in a timely fashion. Continuity means that the client is not neglected, his or her file not lost in a maze of procedures or among other files, and that the services are delivered at the appropriate time. The client is seen as early as possible after the accident and the case manager has continuing responsibility for the client's rehabilitation.

## *Rehabilitation Services Providers*

Essentially there are two bodies of knowledge and two sets of skills required to deliver comprehensive service in rehabilitation.

The first set of skills is embodied in the role of the rehabilitation counsellor trained academically to help people cope with personal problems. It centres on the identification and removal of internal barriers that restrict employability. These can be physical, emotional or social. A person who has the knowledge and skills to identify and remove internal barriers must be trained to appreciate the invisible components of physical injuries.

The second set of skills is required by the employment specialist who gains experience in the workplace. These skills focus on external barriers — those environmental constraints that make re-employment difficult. Among these are work conditions in the community, demands of the workplace and the factors that contribute to job satisfaction.

Employment specialists should have knowledge and experience of the work world. They should keep abreast of changes in employment opportunities in their communities, shifts in demand and requirements in various occupations and methods and style of work productivity. They should also maintain close contact with employers and organized labour and be aware of fluctuations and trends in availability of jobs and in the requirements of the workplace. They should have backgrounds similar to those clients they are serving and wherever possible, have common ethnic, cultural and language ties.

Together the rehabilitation counsellor and the employment specialist help clients and communicate with the public on a daily basis to establish and maintain the reputation of an organization as well as save it unnecessary costs.

At the WCB today this central role is performed mainly by a claims adjudicator who determines the appropriate compensation and refers the client to the Vocational Rehabilitation Division. At the Workers' Compensation and Rehabilitation Board this function would be shared by the rehabilitation team members who would monitor the injury closely, intervene early and design and conduct a rehabilitation program specifically suited to the injured worker.

In the U.S. the determination of the client's vocational potential and strategies for re-employment is performed by "employment counsellors". These individuals have varied backgrounds, often trained to the bachelor's level, but with extensive experience in industry, business or the skilled trades.

Although their job descriptions list a broad range of functions, WCB counsellors state their jobs consist mainly of returning injured workers to employment and attempts to extend the sphere of service are frequently discouraged. At the WCRB, the actual responsibilities of rehabilitation counsellors will change to reflect the case management role and the need for effectiveness in supplying total rehabilitation services to the injured worker.

While most of the rehabilitation counsellors at the WCB are trained academically at least to a bachelor's level, the training rarely includes courses in understanding the behaviour of those who have suffered traumatic events, in counselling techniques, or in methods of serving people with physical disabilities.

They receive a nine-week training program when hired which focuses on an explanation of the administrative structure and service delivery model within which they will work as well as human behaviour in crises situations so they can intervene and help their clients. After this brief exposure to a body of knowledge that normally takes years to master, they are encouraged to learn more, but apparently little incentive is offered to do so.

The counsellors report that what little career advancement does occur is not based on knowledge or performance, but rather on personal relationships and "getting along" within the system. In the long run little advantage is taken of the opportunity to upgrade themselves, or even keep up to changes that are taking place, except by attending conferences as a passive audience.

The Task Force feels strongly that the role of rehabilitation counselling must be redefined and standards set for counsellors that would establish their importance and prestige as case managers. Defining rehabilitation counsellors as case managers implies they should be professionals who are knowledgeable and understand the community's needs. They should have the freedom to design and carry through individualized rehabilitation programs that will help return injured workers to employment whenever possible and to a life of dignity and independence.

To achieve this goal, the Workers' Compensation and Rehabilitation Board must employ counsellors who have training in counselling, empathy towards persons with disabilities and knowledge of the workplace. These employees must recognize that each person is important, possesses human dignity and has the right to equal opportunity.

At the same time, the Task Force recognizes that many rehabilitation counsellors presently working at the board do not have counselling training. While the Canadian Association of Rehabilitation Personnel (CARP) has accredited rehabilitation workers since 1971, it is on the basis of the length of time worked in the field, not on performance or training.

However, CARP is now proposing a new method of accreditation based on quality of experience, a set of skills and a philosophy of rehabilitation that is acceptable in our society. Those professing to become accredited would have to demonstrate their expertise through an examination. While this new proposal is only in the discussion stage at present, its acceptance would be a giant leap forward.

Another problem that emerges in discussions time and again not only with WCB counsellors, but suppliers of services, employers and injured workers is the heavy caseload borne by counsellors. In a Task Force questionnaire, counsellors reported they worked an average of 47.6 hours each week and had an average caseload size of 79.3 cases, indicating an optimum caseload would be about 53.

In a holistic program where purchase of service is emphasized and a case-management approach is introduced, the role of the rehabilitation counsellor will change greatly from what it is now. Caseload size will have to be monitored and expected to vary greatly with the nature of the work, type of client services and location in Ontario.

### *Early Intervention*

Early intervention is an integral part of the case-management process. Based on a study commissioned by the Task Force, 10 reasons were cited for initiating rehabilitation services as soon as possible after the onset of a disability.

1. One can work with the disabled person and the family to prevent the development of psychosocial problems that could interfere with the outcome of the rehabilitation intervention.
2. There will be less confusion for the patient, who can go through the process of coping and adjustment with guidance when needed.
3. Early rehabilitation lets the individual make a personal commitment to re-establish a sense of order in his or her life.
4. The feeling of being alone and abandoned can be decreased or prevented.
5. The person's level of motivation to recover can be stimulated and/or kept high.
6. Family members can be immediately enlisted to provide positive reinforcement to the disabled person.
7. One avoids the waiting period during which patients often begin to build up resentment towards the family, the medical profession and the rehabilitation agency for delays in service.
8. The patient avoids the "runaround" or the feeling of being shuffled from one professional to another.
9. The secondary gains of being disabled can be kept in perspective.
10. Early intervention prevents the patient from settling into the sick role with the disability becoming a way of life.

However, despite its public espousal of early intervention, the WCB admits the average lag time between the date of an injured worker's accident and his or her referral for vocational rehabilitation services has been 17 months. In fact, reports from injured workers, employers and professional organizations that supply rehabilitation services identify a much longer lag time then this.

Early intervention really means "early monitoring" of the injured worker. The case manager must become aware of and involved, in the entire recovery process, not only of the visible injury but invisible injuries as well. The injured worker should be visited in person as soon as possible after the traumatic event by someone trained and sensitive to the assessment of invisible injuries and able to intervene at the right moment.

Yet, because of difficulties in diagnosis or communications, delays can occur. If assessment takes longer than 30 days or the injured worker is not back to work within that period, the Task Force feels the injury should automatically be considered serious and the worker should immediately be referred to a case manager.

# Assessment

There are basically three kinds of assessment used in the rehabilitation process: medical including functional, psychosocial, and vocational including work.

## *Medical and Functional Assessment*

Medical assessment refers to an evaluation by a physician and/or a designate to assess the individual's degree of impairment. Functional assessment is an evaluation by a physician and/or a designate to ascertain the extent of a disability and degree of body function loss. The worker will be asked to perform certain actions which will reveal how much the disability will limit him or her. For example, a functional assessment may indicate that the grip strength of an individual's right hand won't allow him or her to hold a steering wheel. Another test might indicate that his or her eyesight is too poor to distinguish complex forms.

When the injury is serious, the first time the case manager will become involved is during Acute Health Care. At this point the client may have been assessed at a hospital and/or by the family physician. When the diagnosis is clear and uncontested, the case manager can assimilate the information and make the necessary plans for medical and functional rehabilitation.

However, this diagnosis and subsequent recommendations may be in conflict with that of another physician consulted by the board, the employer or the injured worker. At that point the case manager would request the Ontario College of Physicians and Surgeons to appoint a specialist to judge the dispute.

## *Psychosocial Assessment*

Psychosocial assessment refers to an evaluation by a psychologist, social worker or psychiatrist, to determine how badly the worker has been affected or "handicapped" by his or her impairment or disability. Examinations may include psychological tests and interviews.

The assessment may identify areas in the individual's life which are creating barriers to rehabilitation. The impact of the injury may have had a traumatic effect on the worker's self-image, so that the worker believes he or she is incapable of performing similar work again. For example, the head of the household has lost status within the family alienating them from his or her spouse and children. Such conditions are hidden injuries and may be as limiting to successful re-employment as are the physical, visible injuries.

At present, assessment by psychologists, psychiatrists and social workers is purchased on an ad hoc basis. Determination of purchase is made by the medical rehabilitation personnel or by the rehabilitation counsellor.

Little change is contemplated in this area except in regard to two points. First, the case manager rather than the medical practitioner should be the one who makes the referrals and receives the reports for psychosocial assessment. Second, with a holistic definition of rehabilitation, the need for assessment could be more frequent, reflecting a greater sensitivity to invisible injuries.

## *Vocational Assessment*

Vocational assessment refers to an evaluation by a rehabilitation worker of the strengths and weaknesses in an individual's vocational plans. The assessor may be a psychologist, but just as frequently is someone trained in vocational counselling.

Vocational assessment is focused closely on the work to which the client will be referred and measures the strengths and weaknesses of the worker's physical and psychological readiness to choose an occupation, enter it and retain it.

Psychological tests directed towards vocational assessment will normally include personality inventories, intelligence tests, interest batteries and aptitude and achievement tests. Non-psychological tests may include aptitude tests and work samples such as VALPAR and TOWER.

The purchase of vocational assessment from psychologists and the private sector should continue in the future but with greater regard to input from the employment specialists.

## *Work Assessment*

Work assessment is conducted with actual work and measures the degree to which an individual can be successful at a particular job. In practice, it is carried out in environments that most closely resemble the actual work to be performed. Assessment should therefore be made at the site under working conditions or if that is impractical, simulated work sites where the job is done under the direction and evaluation of a trained supervisor.

For instance, the ability to perform janitorial work is evaluated by contracting the worker with a company that provides these services. Another example might be one in which an assembly workshop is used to test the individual's ability to work successfully at an assembly job.

Work assessment should be a way of helping a client who has difficulties in formulating a work plan or one who is anxious about readopting a worker role after a long recovery period. today, unfortunately, it is a way out of a dilemma by desperate counsellors who cannot think of other solutions.

Frequently workshops are established which take contracts for such jobs as parts' assembly, packaging and labelling where individuals can demonstrate reliability, concentration, positive motivation, punctuality and quantity and quality of work output. Such work assessments are generally performed in shops run by non-profit agencies, such as Jewish Vocational Services, Goodwill and COSTI.

# Work Assessment and Work Adjustment Training

While 1985 WCB figures show that 23% of all active cases in the Vocational Rehabilitation Division (VRD) began some form of assessment and 13% started training, the type or quality of programs, their direction and type of clients chosen for each are unknown.

The most likely candidates for work assessment programs seem to be older workers, usually in their 40's or 50's, with no job skills apart from those acquired during their working years. These workers might have been construction labourers, steelworkers, garment workers, miners or forestry workers, whose main assets were a strong back and an abundance of physical energy. Typically, these workers, especially in the urban centres of Southern Ontario, speak little English and have minimum education.

Under the current system, the outcome of an assessment will determine whether the injured worker will continue to be served by the VRD. A poor assessment usually leads the counsellor to conclude the injured worker is competitively unemployable.

No further rehabilitation services are offered and financial assistance in the form of pension supplements or vocational rehabilitation benefits are stopped. In some cases, a new assessment may be arranged but in many cases the worker simply accepts the assessment as it is and gives up.

## *Rehabilitation Workshops*

Rehabilitation workshops generally combine assessment and retraining facilities in the same area. Many of them also include segregated employment services, that is, sheltered workshops. They offer services to people with severe physical or emotional disabilities who may never have experienced regular competitive employment.

Injured workers placed in a segregated workshop complain that the work is boring and tedious. They do not understand the reason they are there and when it is explained, balk at the need to be assessed on such basic factors as "ability to concentrate" and "reliability". So they lose interest, their productivity diminishes and they are frequently absent from work. This leads to a negative report and the counsellor concludes that the injured worker is a malingerer.

In theory, on successful completion of a work adjustment program, the worker should be ready for some employment, likely at a lower entry level job. In reality, success rates, as measured by placement in competitive employment, are extremely low. The Ministry of Community and Social Services, the major funding source for workshops, has estimated that less than 6% of workshop participants are placed in competitive employment.

Serious concerns are raised about the adequacy of these programs and whether they do in fact prepare individuals for competitive employment.

The WCB must provide creative solutions for work assessment and work adjustment training. A large number of innovative programs exist in Canada and in the rest of the world from which the WCB could choose to sponsor or help to create. These would include such programs as competitive employment, supported work, enclaves, community-based workshops, sector-based centres and segregated employment.

### Competitive Employment

Competitive employment for handicapped workers is greatly emphasized in the United States yet few national policies exist to promote disabled workers into the open labour market. Internationally one finds quota systems, government grants, wage subsidies and tax credits to employees as examples of government policies and initiatives that attempt to get disabled workers employed in open industry.

### Supported Work Programs

It has been argued extensively that rehabilitation is based on the assumption that a disabled person must have certain pre-vocational skills before being considered for competitive placement. As a result, many severely disabled individuals who lack these skills have been denied access to mainstream industry. These people find their major vocational alternatives in rehabilitation facilities.

However, advocates for supported employment programs disagree with the need for these pre-vocational skills. Instead they offer a very labour intensive, step-by-step approach for achieving competitive placement. The supported work model places the disabled person in open industry, provides extensive job-site training and ongoing assessment, and, when necessary, receives job-retention assistance from a counsellor. This model emphasizes a "place-train" approach to competitive job placement as opposed to the traditional "train-place" philosophy of vocational rehabilitation.

The labour-intensive aspect of supported work programs relates to the role of the rehabilitation counsellor. Project staff go directly to employers and identify potential jobs for their disabled clients before the employer meets the applicant in a well-rehearsed interview. The counsellor's role does not end with job placement, however. Staff remain involved with the employer and client on an as-needed basis to ensure successful work performance. Each job placement requires the counsellor to deliver on-the-job training to each disabled worker. Behavioural techniques are also used to teach clients to do their jobs more effectively.

### Enclaves

This employment alternative is also referred to as work crews, job worksites, workshops-without-walls, work stations and satellites. Although each term may have a slightly different connotation, the basic concept of a small group of disabled workers in an industrial setting is evident from descriptions of these programs.

Generally, a section of the job site is set aside for workers with disabilities and they are paid either directly by the employer or through subcontracts with the rehabilitation facility.

### Community-Based Centres

Although a number of innovative rehabilitation programs have been introduced, they have failed to make an impact on rehabilitation in general because the government has failed to assist in the innovative spirit to a sufficient degree. Community-based centres are normally established by the private, non-profit sector in the community. Unfortunately many of these centres are poorly equipped due to lack of funding to assess work readiness and perform the function of work adjustment training or work hardening.

Furthermore, although the Ontario Rehabilitation Work Council keeps a record of all existing workshops and has developed accreditation guidelines for performance, the actual services of the workshops are not monitored and they are not required to follow the guidelines.

### Sector-Based Centres

Work assessment should first be found in the industry where the worker was previously employed. To this end, the larger industrial sectors of Ontario should be encouraged to provide worksite analysis to assess the extent to which a worker can return to a job within the industry.

The purpose of a sector-based centre is to perform work assessments and rehabilitate injured workers as much as possible within the industry itself. A number of large industry sectors such as mining, construction, automobile manufacturing and lumbering where a number of accidents occur could develop programs that will return injured workers to the workplace. This holds true for worksite modification and for the development of sector-based centres in communities where industries are located.

Where collective agreements exist within industry, both labour and management should be directed to protect the needs of injured workers and assist in developing and managing the sector-based centres. Where the work force is not organized, the community should participate in their development and management.

### Segregated Employment

Few able-bodied workers are found in the traditional sheltered workshop segregated from mainstream competitive employment and subsidized by external funding to assure its existence. While there are many disadvantages to sheltered workshops, there are several examples of those that have met with success.

It seems that sheltered workshops in Europe do not function as social service agencies but instead take a very business-like approach to their operations. Compared to the U.S., the sheltered workshops in Europe tend to be larger, utilize more modern technology in their operations, pay workers competitive or near competitive wages, provide workers with typical fringe benefits found in industry, tend to be more integrated with disabled and able-bodied employees working together and emphasize long-term rather than transitional employment. While sheltered workshops in the United States are perceived as places for transitional employment until competitive placement can be obtained, European workshops are viewed as permanent, full-time employment for handicapped workers.

# Guidelines to Re-Employment

The Task Force has developed six guidelines which serve as the basis for service delivery within the context of total rehabilitation as the right of all injured workers. They are based on the centrality of the client. People who work at jobs and are seriously injured must be cared for and restored to their previous, pre-injury level of quality of life as much as possible.

1. The preferred re-employment outcome is always the one that most closely approximates the pre-injury job.
2. Preference for re-employment options with competitive employment as the most desirable and no employment as least desirable.
3. The worker is an equal partner in the development of any program of work reinstatement.
4. The pre-injury employer should be consulted in formulating a vocational plan.
5. Rehabilitation services should be purchased in the community from non-profit and private service agencies.
6. Human costs and suffering, loss of income and quality of life, supersede administrative costs.

## *Mandatory Reinstatement*

When the outcome is clear, the injury is visible and return to the worker's former job is straightforward and needs little energy or money, reinstatement tends to offer few problems. In 1985, 48.5% of the total claims made to the WCB were no-lost-time claims. The injured worker returned to his or her previous job without the need of rehabilitation services. However, in 1985 of the total number reported rehabilitated by the VRD, only 36% were returned to the accident employer either to the same job or a modified one with the same employer. In that same period of time, 46% were reported placed with a new company.

In interviews with a randomly selected sample of 120 injured workers who had received vocational rehabilitation services, few reported getting re-employment help from their pre-injury employer. Moreover only 34 of the 120 workers indicated that they were "very satisfied" or "somewhat satisfied" with the help they received from the previous company. Thirty-five percent of the interviewed workers stated their former employers didn't help at all; 18% said they had been offered alternate jobs they couldn't do. Only one in four of the injured workers were offered their old position back, a different one or modified work.

The Task Force supports the worker's right to reinstatement and recommends that he or she have the statutory right to return to the pre-injury job or another job in the same company, respecting seniority rights.

## *Barriers to Re-Employment*

In addition to their handicap, gender, language and cultural barriers also exist for many of the workers because of the difficulties in accepting people, who are different, as equal. They may be immigrants, or children of immigrants, Natives, agricultural workers or people who interact with society rarely because of location, religion or other cultural differences.

Rehabilitation services that approach rehabilitation holistically and focus on handicaps must also be aware of the external barriers to re-employment. Barriers may exist because the community doesn't have enough jobs to ensure the re-employment of the injured worker. The type of job to which the worker is accustomed may have disappeared, not only in the community but in society at large. Or employment conditions may make re-employment at the same or a similar job, in the same community impossible.

What are the figures on the re-employment rate? In the statistics gathered by the Task Force in its study of 120 injured workers, the re-employment rate with the pre-injury employer was 24%. The large majority of injured workers therefore have no alternative but to seek work elsewhere, often without the help of the board except for the threat of losing benefits within a fixed time limit if no job is found.

About 4,000 to 4,500 injured workers are relegated to informal and formal income support systems each year as a result of the VRD's inability to place them in jobs. The Vocational Rehabilitation Division conducts no follow-up of these cases to determine how these unplaced clients will support themselves though many will re-enter the WCB system through additional claims or appeals.

In an ideal system employers would be responsible for all workers injured at the workplace and return them to their pre-injury job, modified work or an alternate position. To this end, the Task Force has recommended that reinstatement be mandatory.

But in reality there are factors that make it difficult for reinstatement to occur: the company may no longer exist; the injured worker does not wish to return to the pre-injury employer; and antagonism and prejudice at the pre-injury job by management or fellow workers may make retention of the job impossible.

Under these conditions the WCB must be pro-active in reducing such barriers. The mission of the board must direct it to intervene in changing negative attitudes towards, and misperceptions of, injured workers.

### *Management Attitudes*

There are a number of misconceptions about injured workers among employers. "Hiring an injured worker only means trouble for my company." "My insurance rates will skyrocket." "They need a lot of expensive worksite modifications." "Their safety records are poor." "Productivity will go downhill." "None of my other employees will accept them."

In fact, none of these statements is true. Earlier and more successful re-employment rates can actually decrease assessment rates. Worksite modifications are usually very inexpensive and if appropriate physical and social changes occur, safety records remain the same or actually improve. Several North American studies show that the productivity of injured employees is actually quite high and whether employees accept the disabled or not really depends on how management sees them.

So the reasons managers give for not hiring the disabled really have no basis in fact. Emotional objections are a little more difficult to address. For example, employers frequently feel that the "invisibly disabled" -- back-injured workers, in particular are malingerers. In fact, according to one study of 2,500 industrially injured workers, only seven were found to be fraudulent. Worse, there seems to be a common North American attitude, that people with disabilities somehow deserve them through their bad, inattentive or lazy behaviour. Moreover, some employers and co-workers simply don't know how to treat or react to an injured person.

Changing negative management attitudes requires communications, education and training to specific results-oriented, behavioral modifications. Positive management attitudes can lead to tolerant management practices toward people with limitations, significantly improving injured worker success and decreasing risk of further disablement.

Any special measures taken to socially integrate injured employees are more successful if dovetailed with general personnel policies and practices that ban discrimination and encourage equal treatment of all minority groups. For a group with physical limitations, the availability of sick time and health benefits, fair promotion practices and employment equity programs all encourage social acceptance of employees with disabilities.

### *Job Modification*

According to the WCB's 1985 annual report, 103,130 workers received pensions for some degree of permanent disability in that year. In 1981, the WCB found that 40% of (non-active cases) injured workers were unemployed. Of this group, 70% had pensions assessed at less than 20%. These figures suggest that most of these people are employable. Their pensions certainly provide no financial incentives to remain unemployed. Evidently not enough is being done to maximize the potential contribution injured workers can make to our economy and their own lives.

Workplace modification expenditures should be viewed by both the WCB and the employer as investments that can save considerable financial resources in the long run and provide real help to injured workers as well as provide considerable prevention of future disabilities. However, job modification is one of the most underutilized programs at the WCB. Spending in this area in 1985 was only $56,013 and although it reached a peak of $101,938 in 1986 it is still a very small part of the $17 million Vocational Rehabilitation Division budget. Yet job modification has the potential of returning a large number of injured workers to the workforce where they can earn a living instead of just getting by on a small pension.

Job modification programs are designed to allow the injured worker to re-enter the workforce as quickly as possible. The reasons for this are apparent. The financial incentive of lower costs through lower lost-time accidents encourages such programs. Reduced costs can be achieved by cutting down on the number of accidents or bringing the injured worker back sooner.

If job modification were taken seriously, then the role of the ergonomist would be extremely important in the rehabilitation process of injured workers, both with accident and new employers. An ergonomically sound examination of the work process provides a dynamic link between health and safety and accessibility, addressing both the issues raised by the reintegration of an injured worker and prevention of similar disabilities. To make this option more effective more employers should be made aware that Section 54 funds are available.

### *Training*

Major changes in the structure of the economy, such as the shift from manufacturing to service jobs and the increased use of advanced technology in production, require a more educated work force. In this changing economy, unskilled, uneducated and older workers will have the most difficult time finding new jobs. Those that are disabled will find it harder still. The demand for an increasingly sophisticated work force means that any training provided should integrate basic skills upgrading with some form of vocational rehabilitation.

For many workers training-on-the job is the most appropriate form of rehabilitation and should be more effectively used, especially in conjunction with other forms of upgrading, and as an entry to a permanent job in the labour market. However, for those injured workers who have not been placed through the rehabilitation services and must anticipate a job search in today's labour market, formal training is likely to enhance their chances of finding meaningful work and should be offered to a greater extent.

The training programs which are used by the Vocational Rehabilitation Division range considerably in their target groups and goals. They include English as a Second Language, training-on-the-job, and formal training programs for technical upgrading, educational upgrading, business training and post-secondary education.

Despite a rapid and continuous rise in the number of workers referred to the VRD over the past five years, the proportion of individuals who began training programs in this period has failed to keep pace. In fact, there has been a steady decrease in the proportion of workers who have gained access to training, from 39.4% of referrals in 1980 to 23.2% in 1985. Thus, only about one-quarter of the injured workers who are deemed eligible for rehabilitation services will get an opportunity to prepare themselves in some way for a relatively hostile labour market.

Training expenditures have also decreased, both in terms of the percentage of Section 54 expenditures allocated to training and in actual dollars spent on training, from about $2.1 million in 1983 to $1.9 million in 1985. Furthermore, for every dollar the board spent directly on rehabilitated workers in 1985, it spent more than $3 on the administrative system to deliver this service. Clearly, spending priorities need to be realigned.

Vocational rehabilitation must not be tied to the degree of disability but to the level of skills required to get a new job. For example, by far the largest majority of claims involved back disabilities. While vocational rehabilitation service might be limited to counselling for job search, what is really needed is retraining or skill upgrading to get access to the type of work which will not make this condition worse.

ESL would be more effective if offered in conjunction with whatever form of training is being provided the injured worker. It should reinforce what is being taught in the program, covering such topics as job search in the related area, health and safety issues referring to the job, tools, techniques and terminology common to the occupational area. Verbal communication should be stressed over written work such as grammar and spelling. Formal training in university and community college programs must be viable options.

Any program which is offered injured workers, especially ESL and vocational training, should be based on their particular requirements. If a worker has gone through upgrading before the accident he/she should have the right to continue to do so after. If the injured worker is entitled to rehabilitation services and wishes to upgrade to a Grade 12 level of education along with vocational retraining, this should also be a right. Completion of upgrading programs such as ESL should not limit access to further training programs. All injured workers should have a right to formal academic or technical training if this is established as the best route to successful rehabilitation in their individual situation.

# Communications

The lack of good, open communications has contributed to confusion and a lack of trust among the WCB, injured workers and employers. This failure to communicate may be caused by language barriers, lack of information to injured workers, the workers' fear of negative consequences if rehabilitation services are requested and failure to listen to the injured workers or admit they may have invisible injuries.

Reasons for the failure to communicate clearly lie in the WCB principles that rehabilitation services are a last resort and money and paperwork can be saved if the injured worker is denied services. But the Task Force feels strongly that goodwill of the injured workers will be obtained, complaints among the public will be reduced, satisfaction and morale among the staff will grow and, in the longer term, money will be saved, if the Workers' Compensation and Rehabilitation Board takes a pro–active role in ensuring that the injured workers are aware of, and participate actively in the development of all rehabilitation services programs.

## *Injured Workers*

The major complaints came from injured workers, especially those who didn't speak English. They complained about the difficulty in understanding what was expected of them and the troubles they encountered trying to tell the WCB their problems. According to a Task Force study, 51.7% of injured workers do not speak English fluently and over 30% have less than a Grade 8 education.

Even when a worker's ability to speak English is fairly good, the next big hurdle is taking on the intricacies of the WCB bureaucratic machine. Correspondence from the board is confusing to even the best–educated reader and incomprehensible to the poorly schooled, older non–English speaker. The system seems arbitrary and unnecessarily bogged down in red tape. Workers who receive assessments at the instigation of the VRD don't understand why they've been given the tests and rarely see the results.

Clearly, counsellors must be able to transcend cultural and language barriers before they undertake case management. They must undergo intensive courses in counselling techniques of the disabled and culturally diverse. Injured workers must be contacted as soon as possible after the accident and informed of their rights and obligations.

### *Employers*

The employers also had problems with understanding or identifying the sources of the pronouncements that came from the WCB — whether general statements about procedures or decisions in specific cases. Employer concerns with communications centred on the lack of information they receive from the VRD regarding the roles they must play in case of an accident, and in their inability to identify responsible staff when needed.

In the WCRB, employers will be kept informed about rehabilitation services by the director of communications in the division and procedures will be organized so that continued communications with employers are maintained on a two-way basis. At the same time, the front line-staff of the division will keep the lines of communication open.

### *Staff*

Finally, the counselling staff complained about the lack of communications within the organization and with agencies and employers. They felt that decisions were being made about their clients by personnel in the claims division without sharing information. They argued that agencies were not giving them feedback when it was needed and of the type that was required.

Many members of the VRD staff are on the road and come into the office once a week. There they pick up informal gossip and have no ways of separating rumours from directives. To help reduce tensions, regular meetings should be held to allow staff to share problems, information and advice that will help them do their jobs more effectively.

### *Research Needed*

With close to half a million claims made each year the WCB could become an important source of knowledge about rehabilitation procedures and helping people who have accidents. Yet if any program evaluations have been conducted, needs assessments or outcome measures studies performed, the results have not been made public. There are no internal staff who are able to conduct such research independently and rarely has the WCB invited such studies externally. In fact, when outside researchers have requested permission to conduct studies of board clients, they have been refused permission.

Two kinds of research could and should be conducted applied research that will help to improve the effectiveness of service delivery of the WCB and basic research that will inform rehabilitation practitioners of the nature and consequences of work-related injuries and diseases. Such research would improve rehabilitation services both within the board and the field in general.

# The Need for Regionalization

The present form of service delivery to injured workers in the North is wholly inadequate. Two predominant factors underlie the growing dissatisfaction with the high cost and time delays in the rehabilitation of injured workers from Northern Ontario. First, the sheer distance and remoteness is a problem which is made worse when workers have to travel to Southern Ontario for assessment and treatment.

Second, there is a perception that the specialists in the South are unfamiliar with, and do not understand, the special conditions in the North, and so make unrealistic assumptions and set unattainable goals. This lack of knowledge about the North on the part of the specialists in the present system had led to inappropriate work assessments.

In 1986, 1,074 injured workers from the Northwest Region and 2,569 injured workers from the Northeast Region were off the job for eight weeks or longer. Furthermore, in the Northwest 660 workers were disabled for longer than 90 days, while in the Northeast the number was 1,665 workers. If one calculates that no more than 60% of all these workers ultimately reach the Toronto facility and spend an average of 21 days of assessment and treatment in Downsview Rehabilitation Centre, this represents about 30,000 treatment days. These days are spent away from the family and represents a substantial cost in travel and lodging in addition to the necessary diagnosis and treatment expenses.

The answer to this situation lies in establishing two rehabilitation facilities in the North, one in Thunder Bay to serve the Northwest and one in Sudbury to serve the Northeast. These two cities have the greatest concentration of population, existing health care facilities and professionals in the North; and are the principal geographical locations for transportation and accessibility in their respective regions.

These rehabilitation facilities should be community-based and managed. They would offer medical and functional assessment rehabilitation services that would be purchased by the Workers' Compensation and Rehabilitation Board. Other rehabilitation services, such as vocational, would be purchased as needed within the local community. Therefore, these facilities would also play a major role in co-ordinating an injured worker's rehabilitation program, with the injured worker's case manager at the Workers' Compensation and Rehabilitation Board.

Services would be purchased as close to the injured worker's home as possible. So, if an injured worker in Sault Ste. Marie needed physiotherapy for an injured arm and it was available in Sault Ste. Marie, then that is where it would be purchased. The injured worker would, therefore, not have to travel to the regional facility in Sudbury.

A model for a regional rehabilitation facility in Sudbury is called the Northeastern Ontario Injured Workers' Rehabilitation Program (IWRP). It is comprised of representatives of business, labour, the municipality, education and health care institutions that want to provide rehabilitation services for injured workers throughout the Northeast.

The IWRP represents a significant community-based initiative to overcome the many shortcomings of the existing WCB rehabilitation system. The Task Force strongly endorses the initiative and recommends the Workers' Compensation and Rehabilitation Board provide initial start-up funding and then purchase services at an appropriate fee. However, the Task Force would also like to see a system where case managers are permitted to make referrals and place injured workers into rehabilitation programs in the centre.

### *The Non-Urban, Non-Industrial Sector*

During the course of its investigations, the Task Force found the WCB had not developed a particularly good relationship with two major communities: the Natives and the agricultural sector.

In general, Natives are unaware of the availability of WCB services to injured workers or have difficulty classifying the type of work performed by band employees. As a result, band members turned to unemployment insurance or welfare for help when an injury occurs. Poor communications and the WCB's lack of understanding of this community paralleled many of the concerns raised by the Ontario Federation of Agriculture.

As a result of the perception that the WCB is designed to serve the industrial and service sectors many farmer owners/operators are unaware of the variety of services available to an injured worker or a family member who is receiving a wage for working on the farm.

An injury to a working member of a family farm can disrupt the whole operation of the farm due to the nature of its workplace. Farmers stated the WCB needed trained staff who had at least a minimum understanding of the different production techniques and practices used in the agricultural sector.

The Task Force found the conditions that presently exist between the two groups and the WCB, of sufficient concern to warrant special attention. The needs of other sectors such as domestics, hunters, trappers and fishermen are also being neglected.

# Final Statement

The experience of the Task Force in the past year was long, painful and emotionally wrenching. The tales of injustice, neglect and rejection recounted by the injured workers throughout the province were so harrowing as to leave the Task Force members disgusted and frustrated.

The WCB has failed to recognize the emergence of a society that is more understanding of the needs of the disabled. It is unresponsive to the fact that hundreds of thousands of workers have become partially or totally disabled in the past years and that society cannot ignore or reject them.

Some of the problems point to legislation that governs service delivery. The *Workers' Compensation Act* was written to eliminate the need for litigation and the search for blame in worksite accidents. It is concerned almost entirely with the concept of an insurance scheme. Little attention is paid to the rehabilitation of the injured worker.

But in the 80s society accepts its responsibility to care for injured workers as human beings, not merely as cogs in industrial wheels. It is not sufficient to restore them physically and then return them to the potentially unsafe working conditions from which they came, or to discard them with woefully inadequate pensions. Clearly the Act must be rewritten to reflect the needs of the workers needs not only for work but for dignity and a quality of life equal to what they had before the injury.

Of course, the main thrust of the Task Force's report has been on the rehabilitation of the injured worker. However, we feel that safety is the cornerstone of rehabilitation and share the concern of the Minister of Labour who has commissioned a number of studies on safety associations. While the amount of money invested in safety associations has risen over the years and employment levels have remained relatively constant, the rate of accidents has increased dramatically.

Some of the blame must also be directed toward the WCB itself. The vagueness of the Act allows for interpretations that can work for the benefit of injured workers or to begrudge them services.

In the Task Force's opinion, the WCB does not spend its funds on vocational rehabilitation effectively which hampers its ability to meet its stated goals. This has a number of important implications. First, referrals to the VRD are kept to a minimum. Second, those who are referred are offered such services as retraining as a last resort and then only if they are younger and better educated. Third, the Vocational Rehabilitation Division has a high rate of recidivism and closures (where further rehabilitation is deemed unnecessary). Finally, when recidivism and closures are taken into account, about 60% of VRD clients do not become re-employed. (Even this figure is conservative since there is no follow-up to determine how many, in fact, stay employed. As it stands, the board considers them "employed" unless they re-enter the system.)

In effect, the WCB does not serve the rehabilitation needs of all injured workers and those who are referred are served inadequately. To meet its existing goals (not to mention those of the Task Force), the WCB cannot continue to make cost control the primary force behind service delivery. This attitude only leads to an adversarial system fraught with litigation and unemployment for the injured worker.

Therefore, the board must be reconstituted to reflect concern with rehabilitation. The organizational structure must be altered to give prominence to the needs of its clients. Its staff must be hired and shaped into delivering a comprehensive, timely service that reflects a total rehabilitation model rehabilitation in all aspects of impairment. The purpose of rehabilitation must be not only to provide vocational assistance but to restore the injured workers to his or her maximum physical, mental, social, vocational and economic usefulness.

Each injured worker must be able to plan his or her holistic rehabilitation program with a case manager who has training in counselling, empathy towards injured workers and knowledge of the workplace. To ensure injured workers obtain appropriate positions after their rehabilitation, employment specialists such as ergonomists and placement specialists must be hired who have a thorough understanding of the workplace, similar backgrounds to the injured workers and the ability to work closely with employers.

Many employees must also be faulted. It is almost as if once they pay their assessments there is no further responsibility for either prevention or re-employment. Employers ought to do far more than paying their premiums to ensure the wellbeing of their workers. Compensation has become a cheap insurance scheme for some employers rather than a system of justice for injured workers.

Clearly there are unions, employers and groups of injured workers who have taken a leadership role in attempting to change the system. However, there are far too many who do no more than is required by law. Changing a monolithic system such as the WCB requires involvement by caring persons at all levels. But, first of all, it requires the government to enact new legislation and translate it into change throughout the system.

# Recommendations to the Minister

## *Recommendations*

### Structure of the Organization

1. That the name of the act be changed from *Workers' Compensation Act* to *Workers' Compensation and Rehabilitation Act* to reflect the importance of the rehabilitation function of the board.

2. That the name of the Board be changed to *Workers' Compensation and Rehabilitation Board.*

3. That the Minister of Labour add one injured worker and a vocational rehabilitation practitioner to the corporate board of the Workers' Compensation and Rehabilitation Board.

4. That four divisions be established, each headed by a vice-president.
   a) Policies & Special Services Division
   b) Strategic Planning & Analysis Division
   c) Compensation Services Division.
   d) Rehabilitation Services Division

5. That the management function of the VP Rehabilitation Services shall be the organization and service delivery of all rehabilitation services of the Board. The organizational structure of the Division shall include three executive directors whose functions are outlined in the appended chart. The titles of these directors should be **Director of Service Quality, Director of Service Delivery,** and **Director of**

## *Rehabilitation Communications*

### Communications

6. That formal meetings of rehabilitation staff be held at least once a month for the staff to discuss policy and official directives and, in turn, to inform management about their experiences, opinions and attitudes and can discuss difficult or interesting cases.

7. That the Director of Rehabilitation Communications establish and maintain a quarterly newsletter for the rehabilitation staff that would inform as well as solicit information and opinion.

8. That staff of the rehabilitation division be required to take training in counselling people with disabilities and people who are culturally diverse.

9. That the case manager's job requires the manager to take time to go to conferences, workshops, field trips and visits to job sites, so that two-way communication avenues be kept open.

10. That WCRB establish a program evaluation system to track the effectiveness of its rehabilitation services and to conduct follow-up studies.

11. That the rehabilitation division establish its own communications arm which will serve to inform, transmit opinion, receive plaudits and complaints, and recommend improvements in service delivery.

12. The WCRB establish a research fund to finance internal and external research into applied and basic problems that deal with conditions of disablement, occupational health and safety, outcome research and other areas of interest to rehabilitation of injured workers.

## *The Right to Total Rehabilitation*

13. Any worker who sustains a serious injury or a debilitating disease linked to the workplace, shall have the statutory right to all rehabilitation required by that worker. Rehabilitation shall be defined as "to assist workers who have suffered occupational injuries or debilitating diseases linked to the workplace in the process of restoration, to the fullest physical, mental, social, vocational and economic independence to the maximum possible extent". Serious shall be defined as a situation in which the worker is unable to return to the job within 30 days of injury.

14. That the board take a proactive role in identifying those injured workers who have not received, have been denied, or were never referred to rehabilitation services and that the board accept the responsibility of supplying satisfactory rehabilitation services and ensuring financial security.

15. That all cases in WCB which have been open more than 30 days but not referred to Vocational Rehabilitation Services be referred for service under the broader definition of rehabilitation.

16. That the board take a proactive role in identifying those injured workers who have received vocational rehabilitation services but are dissatisfied with the rehabilitation services received and that the board accept the responsibility of supplying satisfactory rehabilitation services and ensuring financial security.

### Re-Employment Issues

17. That the Ministry of Labour draft a resolution similar to the Quebec legislation which reads: "No person may refuse to hire a worker because the worker has suffered an employment injury if the worker is able to carry on the employment contemplated.

18. That a worker who is injured at the workplace or contracts an occupational disease shall have the statutory right to return to the preinjury job. Where the worker is no longer capable of performing that job he or she shall have the right to another job in the same enterprise, respecting seniority rights.

19. That where the company no longer exists, the Injured Worker shall be assisted by the Rehabilitation Division of WCRB to find alternate employment.

## *Assessment and Work Adjustment Training*

20. That where a dispute arises among medical practitioners regarding the diagnosis and functional assessment of the injured worker, the case manager shall request the Ontario College of Physicians and Surgeons to appoint a specialist to adjudicate the dispute.

21. That adjudication shall take place within 30 days of notification of the existence of the dispute and that the results shall be given to the case manager.

22. During the period of review by the adjudicator full financial benefits shall be continued.

23. That should no agreement in diagnoses then be obtained, or the worker or employer refuse to concur with the outcome, the case shall be taken to an appeals system for adjudication.

24. That the WCRB take a pro-active role in working with the community to reduce environmental barriers to the employment of people with physical or emotional injuries.

25. That the trend of decreasing expenditures for training be reversed to reflect the value of training as a rehabilitation tool for injured workers.

26. That the Minister of Labour initiate and co-ordinate efforts among the provincial and federal government, management and labour to establish sector-based skill training centres in appropriate areas of the province open to all people requiring skill training.

27. That the management of the sector-based rehabilitation centres be constituted with labour and management, or, where labour is not organized, with rehabilitation practitioners and worker representatives from the community.

28. That the Minister of Labour, in co-ordination with the Minister of Community and Social Services, and in co-operation with representatives from industry and community based rehabilitation agencies, initiates the development of accreditation standards for rehabilitation workshops and activity facilities in Ontario.

29. That accreditation standards should be put into place within two years of receipt of this recommendation.

30. That WCRB refer clients for assessment and work adjustment only to those workshops that are accredited and can demonstrate an evaluation process to monitor their quality of service.

31. That the Minister of Labour initiate and co-ordinate efforts among the provincial and federal government to establish affirmative industries in all the major communities in Ontario to supply employment that would allow the gradual return of injured workers to competitive employment.

32. That the WCRB render such rehabilitation and compensation services as necessary to restore disabled workers to social and economic independence.

33. That where the case manager is dissatisfied with a report from purchased rehabilitation services, the case manager must be able to purchase alternative services.

34. That where a worker contests a recommendation made by the case manager, the worker shall have the right of appeal to the case manager's supervisor. The worker always shall have the right to request another case manager following a review by the supervisor.

35. That where the employer or the employee is dissatisfied with the outcome of the recommendations reached by the case manager and the case manager's supervisor, they shall retain the right to appeal to the appeals system.

### *Job Modification*

36. That the WCRB take a pro-active role in promoting job modification practice in Ontario by increasing the number of trained ergonomists on staff making use of trained personnel in the community.

37. That the WCRB advertise its availability to assist businesses with expert advice and financial incentives in the development of job modification programs.

38. That personnel hired by the WCRB in the capacity of ergonomists shall have appropriate training in ergonomic planning and assessment.

39. That the WCRB shall respond in 30 days to employer requests for assistance in job modification.

### *Case Management*

40. That each file of an injured worker that comes to Rehabilitation Services shall become the responsibility of a single staff worker, called the case manager, who shall receive the file from the intake counsellor and be responsible for choice and delivery of appropriate service until one year after the file is closed.

41. That the case manager shall be responsible for appropriateness, comprehensiveness and continuity of the service provision.

42. That the functions of the case manager shall include the following:

    - to assess the injured worker's needs
    - to develop a therapeutic relationship with the injured worker
    - to plan and organize all rehabilitation services
    - to procure and expedite services

- to keep records of services given and costs incurred
- to advocate for and represent the client
- to organize and manage the entire caseload.

43. That the process of rehabilitation service delivery followed by the case manager shall be as illustrated in the flow chart.

44. That the case manager involve the injured worker as a partner in all rehabilitation decisions so that the injured worker shall be a participant in all phases of service selection.

45. The training of the case manager shall be that of the rehabilitation counsellor at a level that would give her or him recognition as a senior member of the rehabilitation team.

### *Rehabilitation Services Providers*

46. That rehabilitation counsellors with experience be recognized as case managers in the rehabilitation services delivery system.

47. That case managers shall have the freedom to design individualized rehabilitation programs to fit the uniqueness of every injured worker.

48. That each case manager shall provide direct services to injured workers to the extent that his or her training, skills, and abilities will allow.

49. That rehabilitation counsellors be encouraged to investigate and select services in the community not provided by WCRB, based on assessment of effectiveness and quality of service.

50. That all rehabilitation counsellors be required to continually visit and monitor employment conditions in the workplace.

51. That all rehabilitation counsellors be required to present the WCRB to employers, workers, professional groups and the public at large by maintaining positive two-way communications.

52. That rehabilitation counsellors presently employed at Workers' Compensation Board be required and encouraged to upgrade their formal education to a graduate level in a program that stresses counselling skills.

53. That all personnel to be hired in the future at WCRB as rehabilitation counsellors shall have training at a graduate level in programs that stress counselling skills. That recognition be

given to work experience and that the board provide the time and financial incentives to train to a graduate level.

54. That the Minister of Labour work with the Minister of Colleges and Universities to actively promote the establishment in Ontario of a graduate level program that would train rehabilitation counsellors for certification.

55. That the Minister of Labour join with the Minister of Health and Minister of Community and Social Services to actively promote the establishment in Ontario of a system of certification of rehabilitation counsellors.

56. That the WCRB actively encourage and fund a programme of continuing education and upgrading of its staff so that they continue to maintain their skills.

57. That the WCRB be required to provide on-site training at industries in the community so that rehabilitation counsellors maintain and enhance knowledge of the workplace.

58. The caseload size of rehabilitation counsellors should be allowed to vary according to the amount of work each case requires, but should be set by management in consultation with the counsellors with due regard to the demands of a high quality of service and not allowed to rise above 50.

59. That employment specialists be hired from among the working population in each community where a regional rehabilitation office exists to work with the case managers in formulating rehabilitation goals and programs.

60. That employment specialists shall assist in setting up retraining sites in the community and also assist injured workers in job search.

61. That employment specialists be representative of the ethnic populations of their communities and proportionally representative of the sectors of the injured workers population.

62. That these employment specialists be provided by the board with training from a qualified institution in Ontario that offer educational opportunities in rehabilitation, job management and ergonomics.

## Early Intervention

63. That when workers are injured at the workplace, or are discovered to have contracted a debilitating disease linked to the workplace, the following procedure in partnership with the injured worker, be followed:

    a) the injured worker be provided immediate Acute Health Care Services.
    b) A claims file shall be opened at the nearest WCRB office.
    c) If the injury or disease is considered by Acute Health Care Services to be serious, or is a reoccurrence of the previous injury, or is reopened, Health Care Services shall notify the claims officer immediately who shall then transfer the file to an intake counsellor of the WCRB Rehabilitation Services for immediate initiation of rehabilitation services.
    d) If the injured worker is unable to return to work within 30 days, or if a file remains open for 30 days for whatever reason, the claims officer shall transfer the file to the intake counsellors of the WCRB for immediate initiation of services.
    e) All injured workers who are receiving rehabilitation services shall receive full benefits as long as they are receiving these services.
    f) Injured workers who have not been referred to rehabilitation services can request rehabilitation services and shall be referred immediately to the intake counsellor for service.

64. That the WCRB takes a pro-active role in contacting injured workers as soon as possible after the event, informing them of their rights and insuring that the injured workers fully understand their rights and obligations.

## Regionalization

65. That the Minister of Labour adopt all the recommendations of the Downsview Rehabilitation Centre Review Team, including those concerned with the cessation of vocational assessments at Downsview Rehabilitation Centre.

66. That medical and functional assessment and therapeutic services be purchased from local community hospitals wherever possible. Where such services do not exist, the Minister of Labour should work closely with the Minister of Health to assist actively in the establishment of medical and functional assessment centres in the local communities.

67. That rehabilitation services, in all its facets, including medical, psychosocial, vocational and work adjustment, should be purchased by the Case manager from community institutions, organizations or private services in the communities wherever they are available.

68. That when an appropriate rehabilitation service does not exist in the local community, WCRB should assist actively with advice and financial incentives in the establishment of such services.

69. That WCRB should decentralize its services and establish rehabilitation offices staffed by case managers and employment specialists in local communities as far as possible.

### *Northern Ontario: Decentralization of Rehabilitation Services*

70. That community based regional rehabilitation facilities be established in Thunder Bay and Sudbury to provide rehabilitation services to injured workers in Northern Ontario, with:
    a) initial funding provided by the WCRB, and
    b) that the WCRB purchase services on an appropriate fee-for-services basis.
71. That the WCRB case manager in conjunction with the rehabilitation facilities purchase rehabilitation services from the community.

72. That rehabilitation services be purchased as close as possible to the injured worker's residence.

73. That the Northeastern Ontario Injured Workers' Rehabilitation Program open referrals from managers of the WCRB.

74. That the community in Thunder Bay and the Northwest region of Northern Ontario, with an interest in the rehabilitation of injured workers, develop a rehabilitation facility using the community based model of the Injured Workers Rehabilitation Program for Northeastern Ontario as a guide.

75. That the Minister of Labour in conjunction with the Minister of Northern Development and Mines, the Minister of Health and the Minister of Colleges and Universities, develop programs and incentives that will encourage and assist students in Northern Ontario to enter into education and training in the health care

field in greater numbers and to desire employment in their field of study and profession in Northern Ontario.

76. That the Minister of Labour in conjunction with the Ministers of Intergovernmental Affairs, Northern Development and Mines, and Health, undertake discussions with their federal government counterparts to encourage the possible immigration of health care professionals who wish to practice in Northern Ontario.

## *Non–urban, Non–industrial Sector*

77. That the WCRB initiate a dialogue with representatives of Native Bands to discuss the present rating schedule and rehabilitation needs of the community, taking into account such factors as the unique socioeconomic existence of Natives in Ontario.

78. That the WCRB initiate a dialogue with representatives of the agricultural community towards providing rehabilitation services that are relevant, accessible and appropriate for that community.

79. That the Director of Communications of the WCRB Rehabilitation Division develop channels of communication between the WCRB and the native community and the agricultural sector, with the goal of establishing the following:
    - a discussion of benefits and costs, and the potential usefulness of rehabilitation;
    - clear and complete guidelines for undertaking coverage by WCRB and making full use of its services and benefits;
    - an outline of these services and benefits as they apply to Native people in urban, rural, and remote settings, and to traditional and non–traditional forms of work;

80. That the WCRB identify other non–industrial and non–urban sectors or communities, such as the fishing industry and non–Native hunters and trappers in Ontario, and ensure that effective lines of communication exist or are established so that rehabilitation services to these sectors are relevant and effective.

## *Review*

81. That a re–evaluation be made on the targeting of safety dollars.

82. That rehabilitation be enshrined in the Act as Regulation 949 under the *Workers' Compensation Act*.

83. That a tri-party committee (labour, industry and ministry) be established to convert the Vocational Task Force recommendations into regulations.

84. That a tri-party committee (labour, industry and ministry) be established, either as a standing committee or otherwise, with the power to make amendments, adjustments and recommendations to the regulations.

Ontario

$10.00

# "an injury to one is an injury to all"

## The Report of the Ontario Task Force on the Vocational Rehabilitation Services of the Workers' Compensation Board

# AN INJURY TO ONE
# IS AN INJURY TO ALL

## Towards Dignity and Independence For the Injured Worker

Report of the
Ontario Task Force on the Vocational Rehabilitation
Services of the Workers' Compensation Board

Ontario
August 1987

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August 1987

The Honourable William Wrye,
Minister of Labour,
Government of Ontario,
Toronto, Ontario.

Dear Mr. Wrye:

We are pleased to submit to you the Report of the Task Force on the Vocational Rehabilitation Services of the Workers' Compensation Board.

We have arrived at this report following an extensive process of twenty-one public hearings throughout the Province, consideration of research reports that we commissioned and numerous meetings on our part.

The process has been a difficult one. In addition to a multitude of points and issues to consider, we have had to deal with the emotional impact of the public hearing testimony from injured workers and other constituencies. At times we have found it hard to imagine that such a situation of neglect and mistreatment can exist within our Province.

We have been frustrated in our research endeavors by certain senior members of the Workers' Compensation Board. This lack of cooperation lead to numerous delays in the required research and consequently delayed the completion of this report.

We believe that we have dealt effectively with the terms of reference you set out for us in May of 1986. However, in order to present to you a comprehensive reform model we have had to undertake a holistic approach to the rehabilitation of injured workers. Consequently, our comments and recommendations are not limited to a narrow focus only on vocational rehabilitation.

In submitting this report to you it is our hope that our research efforts and recommendations will result in a more responsive and comprehensive approach to the rehabilitation of injured workers.

Yours sincerely,

Maria Minna

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## Acknowledgements

*We, the members of the Task Force, would like to thank our families and friends for being so agreeable during our absence from home during public hearings, and numerous weekends and late evenings while writing this report.*

*We would like to compliment the hundreds of injured workers who came forward during the public hearings to tell their stories, which were of a personal nature, in the hope that others would not meet with a similar fate. In addition, we wish to compliment those members of industry, labour, non-profit rehabilitation organizations, legal clinics, and the medical profession, among others, who took the time to prepare and submit most insightful briefs to the Task Force. Often, this work was done on their own time.*

*We would also like to thank the cities of Thunder Bay, Scarborough and Mississauga for providing us with the use of their council chambers for public hearings.*

*Finally, we would like to thank our staff and research team for their time, energy and assistance in the writing of this report.*

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## Chapter 1

# Introduction

- *executive summary*
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* * *

*There was a girl in there while I was in there. She had an operation on her back. She had a steel rod in her back. They had her doing things in the gym that I wouldn't even attempt. She was due to go in for another operation. You could actually hear that nut moving around in her back. She is the sole supporter for herself.*

*I said, "Why are you doing this? If that thing lets go, you are going to be in a wheelchair for the rest of your life." She sat there and cried and said, "Jackie, what am I going to live on? I have to do what they say." This is not right to do this to people.*

Mrs. Jackie Burton
Injured Worker
Peterborough, November 19, 1986

* * *

*...he started asking me questions, like... "do you have strange fantasies, like taking a dog to bed, or do you fantasize on door knobs" and that, and I just thought, well, how degrading was he to ask questions like that to me, but I'll play along with his game. Anything to get out of the hospital...*

Name Withheld
Injured Worker (name withheld)
Windsor, November 6, 1986

* * *

*If you've got a heart condition and you're in the swimming pool with 80 degree plus water, doing exercise like volley ball, or running back and forth, and calisthenics, and all this stuff in the water, the exertion and the heat is bad for your heart, and, of course, I never knew this, and I went along with it as much as you can, because, if you don't a patient does not participate, is checked off, or if you just out and out sit down, the patient [who] is not co-operating is checked out. After two weeks of this, I had a heart attack.*

Dave Beckett
Injured Worker
Windsor, November 6, 1986

* * *

## Executive Summary

On May 14, 1986, the Honourable William Wrye, Minister of Labour, announced the formation of a Task Force to examine the rehabilitation services that were being provided by the Workers' Compensation Board (WCB) of Ontario.

On that date he also announced the appointment of the two chairpersons. The rest of the nine-member Task Force were appointed in September of that year. It began its investigation in the fall of 1986 and held 21 public hearings in 19 centres throughout the province in October, November and December. During these emotionally wrenching hearings the Task Force realized the severity of the situation that existed in Ontario and recognized the consistency with which identical complaints were voiced across the province.

Presentations were received from industry, legal clinics, unions, health professionals in the private and profit sectors, not-for-profit organizations, the Union of Injured Workers and similar groups of injured workers. But the greatest impact came from the workers themselves who talked about their wretched conditions and the treatment they had received at the hands of the WCB.

In addition to the hearings and submissions from 201 organizations, agencies and individuals, 11 studies were commissioned to investigate various aspects of the problems in depth. Some of the studies were conducted by the staff of the Task Force, but as the need for information mounted, other reports were purchased on a contractual basis.

Numerous delays were encountered by the research teams who, though continually frustrated in their attempts to elicit information from the WCB, were finally able to gather what they needed to compile a comprehensive data base.

From January 1987, the Task Force met repeatedly to evaluate the information, draw conclusions and formulate the recommendations that would be advanced to the Minister.

Consensus on these recommendations has now been reached and they are presented in this report.

The Task Force found a disturbing trend in recent years of increased numbers of disabling injuries in the workplace which have far exceeded the growth of the labour force. Almost half of worker injuries in Ontario result in lost time and the substantial number of pension awards points to a large pool of workers for whom a smooth reintegration into the work force is often impossible.

Many of these workers would benefit from timely access to vocational rehabilitation services, yet only 6% are referred to the Vocational Rehabilitation Division (VRL) and a mere 3.3% of the total WCB budget was set aside for this purpose in 1986. Their disabilities were often severe, long-term and intractable, preventing them from returning to their former jobs. Considering the difficulty of reintegration into the work force, it is appalling that only a quarter of the small number of injured workers referred to the Vocational Rehabilitation Division received training of any kind.

The most outstanding feature of the present model of rehabilitation was the lack of concern for the injured worker's condition apart from the requirements needed to return him or her to the job. The style of service delivery seemed to be one of callous disregard of the emotional impact of the work-related injury or disease on the totality of the individual.

The Task Force felt strongly that changes in service delivery could not be restricted to a series of patchwork solutions but had to get to the essence of the matter. The front line staff could hardly be faulted for carrying out a policy of which they had little understanding or sympathy.

The Task Force therefore formulated a number of principles. These are as follows:

- Rehabilitation shall be holistic: treating all aspects of the disability: physical, mental, social, vocational and economic.
- Rehabilitation shall be the right of every injured worker, not merely offered as a last resort.
- The injured worker shall be an equal partner in formulating a rehabilitation plan and carrying it through.
- Rehabilitation services shall become one of the central thrusts of the board, demonstrated by the appointment of a vice president to represent the interests of rehabilitation.
- The change in emphasis shall be demonstrated by changing the name of the board to the *Workers' Compensation and Rehabilitation Board* and adding a rehabilitation professional and an injured worker to its corporate board.
- Injured workers shall have the statutory right to reinstatement with the preinjury employer at the same or a modified job. Where this outcome is impossible, the rehabilitation services will help find other work, offering retraining towards a satisfying, meaningful job or relocation to another community.
- Injured workers shall be provided with emotional, social and economic rehabilitation so their quality of life shall be restored to the maximum possible independence. Case managers shall be appointed to design and supervise rehabilitation programs for each injured worker. The case managers shall be trained in rehabilitation counselling and will be responsible for ensuring comprehensiveness and timeliness of service delivery.
- Intervention with rehabilitation services shall begin as soon as the seriousness of the injury is identified and in any case no later than 30 days following the injury. An intake worker in the Division shall monitor the client and intervene with help at the optimum time.
- Rehabilitation services shall be regionalized and offered as close to the client's home as possible. Regional centres shall be set up in all large communities, including Northern Ontario.
- Medical and functional rehabilitation shall be purchased at local hospitals, and the Minister shall encourage the establishment of medical rehabilitation services in

communities, not restricted to Workers' Compensation clients.

- The Minister shall encourage the establishment of accredited rehabilitation worksites in co-ordination with the employment sector and in the community, to deliver vocational rehabilitation, including work assessment.
- The board shall develop an effective strategy to communicate openly with the public, to seek feedback on its effectiveness and to encourage program evaluation, outcome research and basic research into the causes, prevention and rehabilitation of disabilities.

These principles are embedded in the recommendations presented to the Minister of Labour. The Task Force recommends that the Minister of Labour direct the board to implement the majority of the changes immediately as they do not require legislation and are within the power of the board. The recommendations specifically referred to are 4–8, 25, 31–32, 36–54, 57–81, and 83–84.

## *Recommendations*

### Structure of the Organization

1. That the name of the Act be changed from *Workers' Compensation Act* to *Workers' Compensation and Rehabilitation Act* to reflect the importance of the rehabilitation function of the board.
2. That the name of the board be changed to *Workers' Compensation and Rehabilitation Board* (WCRB).
3. That the Minister of Labour add one injured worker and a vocational rehabilitation practitioner to the corporate board of the Workers' Compensation and Rehabilitation Board.
4. That four divisions be established, each headed by a vice-president.
    a) Policies & Special Services Division
    b) Strategic Planning & Analysis Division
    c) Compensation Services Division.
    d) Rehabilitation Services Division
5. That the management function of the VP, Rehabilitation Services, shall be the organization and service delivery of all rehabilitation services of the board. The organizational structure of the division shall include three executive directors whose functions are outlined in the appended chart (see page 50). The titles of these directors should be *Director of Service Quality, Director of Service Delivery,* and *Director of Rehabilitation Communications*.

### Communications

6. That formal meetings of rehabilitation staff be held at least once a month for the staff to discuss policy and official directives and, in turn, to inform management about their experiences, opinions and attitudes and discuss difficult or interesting cases.
7. That the rehabilitation division establish its own communications arm which will serve to inform, transmit opinion, receive plaudits and complaints, and recommend improvements in service delivery.
8. That the Director of Rehabilitation Communications establish and maintain a quarterly newsletter for the rehabilitation staff that would inform as well as solicit information and opinion.
9. That staff of the rehabilitation division be required to take training in counselling people with disabilities and people who are culturally diverse.
10. That the case manager's job requires the manager to take time to go to conferences, workshops, field trips and visits to job sites, so that two-way communication avenues can be kept open.
11. That the Workers' Compensation and Rehabilitation Board establish a program evaluation system to track the effectiveness of its rehabilitation services and to conduct follow-up studies.
12. That the Workers' Compensation and Rehabilitation Board establish a research fund to finance internal and external research into basic and applied issues that deal with conditions of disablement,

occupational health and safety, outcome research and other areas of interest to rehabilitation of injured workers.

## The Right to Total Rehabilitation

13. That any worker who sustains a serious injury or a debilitating disease linked to the workplace, shall have the statutory right to all rehabilitation required by that worker. Rehabilitation shall be defined as "to assist workers who have suffered occupational injuries or debilitating diseases linked to the workplace in the process of restoration, to the fullest physical, mental, social, vocational and economic independence to the maximum possible extent". Serious shall be defined as a situation in which the worker is unable to return to the job within 30 days of injury.
14. That the board take a pro–active role in identifying those injured workers who have not received, have been denied, or were never referred to rehabilitation services and that the Board accept the responsibility of supplying satisfactory rehabilitation services and ensuring financial security.
15. That all cases in WCB which have been open more than 30 days but not referred to Vocational Rehabilitation Services be referred for service under the broader definition of rehabilitation.
16. That the board take a pro–active role in identifying those injured workers who have received vocational rehabilitation services but are dissatisfied with the rehabilitation services received and that the board accept the responsibility of supplying satisfactory rehabilitation services and ensuring financial security.

## The Right to Employment

17. That a worker who is injured at the workplace or contracts an occupational disease shall have the statutory right to return to the pre–injury job. Where the worker is no longer capable of performing that job he or she shall have the right to another job in the same enterprise, respecting seniority rights.
18. That where the company no longer exists, the injured worker shall be assisted by the Rehabilitation Division of Workers' Compensation and Rehabilitation Board to find alternate employment.
19. That the Minister of Labour ensure that Section 9 of the Ontario Human Rights Code, 1981, is incorporated in the Workers' Compensation and Rehabilitation Board Act.

## Assessment and Work Adjustment Training

20. That where a dispute arises among medical practitioners regarding the diagnosis and functional assessment of the injured worker, the case manager shall request the Ontario College of Physicians and Surgeons to appoint a specialist to adjudicate the dispute.
21. That adjudication shall take place within 30 days of notification of the existence of the dispute and that the results shall be given to the case manager.
22. That during the period of review by the adjudicator full financial benefits shall be continued.
23. That should no agreement in diagnoses then be obtained, or the worker or employer refuse to concur with the outcome, the case may be taken to an appeals system.
24. That the Workers' Compensation and Rehabilitation Board take a pro–active role in working with the community to reduce environmental barriers to the employment of people with physical or emotional injuries.
25. That the trend of decreasing expenditures for training be reversed and reflect the value of training as a rehabilitation tool for injured workers.
26. That the Minister of Labour initiate and co–ordinate efforts among the provincial and federal government, management and labour to establish sector–based skill training centres in appropriate areas of the province open to all people requiring skill training.
27. That the management of the sector–based rehabilitation centres be constituted with labour and management, or, where labour is not organized, with rehabilitation practitioners and worker representatives from the community.
28. That the Minister of Labour, in co–ordination with the Minister of

Community and Social Services, and in co–operation with representatives from industry and community–based rehabilitation agencies, initiate the development of accreditation standards for rehabilitation workshops and activity facilities in Ontario.

29. That accreditation standards should be put into place within two years of receipt of this recommendation.
30. That the Workers' Compensation and Rehabilitation Board refer clients for assessment and work adjustment only to those workshops that are accredited and can demonstrate an evaluation process to monitor their quality of service.
31. That the Minister of Labour initiate and co–ordinate efforts among the provincial and federal government to establish affirmative industries in all the major communities in Ontario to supply employment that would allow the gradual return of injured workers to competitive employment.
32. That the Workers' Compensation and Rehabilitation Board render such rehabilitation and compensation services as necessary to restore disabled workers to social and economic independence.
33. That where the case manager is dissatisfied with a report from purchased rehabilitation services, the case manager must be able to purchase alternative services.
34. That where a worker contests a recommendation made by the case manager, the worker shall have the right of appeal to the case manager's supervisor. The worker shall have the right to request another case manager following a review by the supervisor.
35. That where the employer or injured worker is dissatisfied with the outcome of the recommendations reached by the case manager and the case manager's supervisor, they shall retain the right to appeal.

## Job Modification

36. That the Workers' Compensation and Rehabilitation Board take a pro–active role in promoting job modification practice in Ontario by increasing the number of trained ergonomists on staff making use of trained personnel in the community.
37. That the Workers' Compensation and Rehabilitation Board advertise its availability to assist businesses with expert advice and financial incentives in the development of job modification programs.
38. That personnel hired by the Workers' Compensation and Rehabilitation Board in the capacity of ergonomists shall have appropriate training in ergonomic planning and assessment.
39. That the Workers' Compensation and Rehabilitation Board shall respond in 30 days to employer requests for assistance in job modifications.

## Case Management

40. That each file of an injured worker that comes to Rehabilitation Services shall become the responsibility of a single staff worker, called the case manager, who shall receive the file from the intake counsellor and be responsible for choice and delivery of appropriate service until one year after the file is closed.
41. That the case manager shall be responsible for appropriateness, comprehensiveness and continuity of the service provision.
42. That the functions of the case manager shall include the following:
    - to assess the injured worker's needs
    - to develop a therapeutic relationship with the injured worker
    - to plan and organize all rehabilitation services
    - to procure and expedite services
    - to keep records of services given and costs incurred
    - to advocate for and represent the client
    - to organize and manage the entire caseload.
43. That the process of rehabilitation service delivery followed by the case manager shall be as illustrated in the flow chart (See Appendix F).

44. That the case manager involve the injured worker as a partner in all rehabilitation decisions so that the injured worker shall be a participant in all phases of service selection.

45. That the training of the case manager shall be that of the rehabilitation counsellor at a level that would give him or her recognition as a senior member of the rehabilitation team.

## Rehabilitation Services Providers

46. That rehabilitation counsellors with experience be recognized as case managers in the rehabilitation services delivery system.

47. That case managers shall have the authority to design individualized rehabilitation programs to fit the uniqueness of every injured worker.

48. That each case manager shall provide direct services to injured workers to the extent that his or her training, skills and abilities will allow.

49. That rehabilitation counsellors be encouraged to investigate and select services in the community not provided by Workers' Compensation and Rehabilitation Board, based on assessment of effectiveness and quality of service.

50. That all rehabilitation counsellors be required to continually visit and monitor employment conditions in the workplace.

51. That all rehabilitation counsellors be required to present the Workers' Compensation and Rehabilitation Board and its services to employers, workers, professional groups and the public at large by maintaining positive two–way communications.

52. That the Workers' Compensation and Rehabilitation Board provide time, funds and recognition for continuing education and upgrading of its rehabilitation staff so that they continue to maintain their skills.

53. That rehabilitation counsellors presently employed at Workers' Compensation Board be required and encouraged to upgrade their formal education to a graduate level in a program that stresses counselling skills.

54. That all personnel to be hired in the future at Workers' Compensation and Rehabilitation Board as rehabilitation counsellors shall have training at a graduate level in programs that stress counselling skills. In exceptional circumstances, that recognition be given for work experience and that the board provide the time and financial incentives to train to a graduate level.

55. That the Minister of Labour work with the Minister of Colleges and Universities to actively promote the establishment in Ontario of a graduate level program that would train rehabilitation counsellors for certification.

56. That the Minister of Labour, in co–operation with representatives from industry and community–based rehabilitation agencies, join with the Minister of Health and Minister of Community and Social Services to actively promote the establishment in Ontario of a system of certification of rehabilitation counsellors.

57. That the Workers' Compensation and Rehabilitation Board be required to provide onsite training at industries in the community so that rehabilitation counsellors maintain and enhance knowledge of the workplace.

58. That the caseload size of rehabilitation counsellors should be allowed to vary according to the amount of work each case requires, but should be set by management in consultation with the counsellors with due regard to the demands of a high quality of service and not allowed to rise above 50.

59. That employment specialists be hired from among the working population in each community where a regional rehabilitation office exists to work with the case managers in formulating rehabilitation goals and programs.

60. That employment specialists shall assist in setting up retraining sites in the community and also assist injured workers in job search.

61. That employment specialists reflect the ethnic population of the workforce and be

proportionally representative of the sectors of the injured workers population.

62. That these employment specialists be provided by the Board with training from a qualified institution that offers educational opportunities in rehabilitation, job management or ergonomics.

## Early Intervention

63. That when workers are injured at the workplace or are discovered to have contracted a debilitating disease linked to the workplace, the following procedure, in partnership with the injured worker, be followed:

    a) the injured worker be provided immediate Acute Health Care Services.

    b) A claims file shall be opened at the nearest Workers' Compensation and Rehabilitation Board office.

    c) If the injury or disease is considered by Acute Health Care Services to be serious, or is a reoccurrence of the previous injury, or is reopened, Health Care Services shall notify the claims officer immediately who shall then transfer the file to an intake counsellor of the Workers' Compensation and Rehabilitation Board, Rehabilitation Services for immediate initiation of rehabilitation services.

    d) If the injured worker is unable to return to work within 30 days, or if a file remains open for 30 days for whatever reason, the claims officer shall transfer the file to the intake counsellors of the Workers' Compensation and Rehabilitation Board for immediate initiation of services.

    e) All injured workers who are receiving rehabilitation services shall receive full benefits as long as they are receiving these services.

    f) Injured workers who have not been referred to rehabilitation services can request rehabilitation services and shall be referred immediately to the intake counsellor for service.

64. That the Workers' Compensation and Rehabilitation Board takes a pro–active role in contacting injured workers as soon as possible after the event, informing them of their rights and ensuring that the injured workers fully understand their rights and obligations.

## Regionalization

65. That the Minister of Labour adopt all the recommendations of the Downsview Rehabilitation Centre Review Team, including those concerned with the cessation of vocational assessments at Downsview Rehabilitation Centre.

66. That medical and functional assessment and therapeutic services be purchased from local community hospitals wherever possible. Where such services do not exist, the Minister of Labour should work closely with the Minister of Health to assist actively in the establishment of medical and functional assessment centres in the local communities.

67. That rehabilitation services, in all its facets, including medical, psychosocial, vocational and work adjustment, should be purchased by the case manager from community institutions, organizations or private services in the communities wherever they are available.

68. That when an appropriate rehabilitation service does not exist in the local community, the Workers' Compensation and Rehabilitation Board should assist actively with advice and financial incentives in the establishment of such services.

69. That the Workers' Compensation and Rehabilitation Board should decentralize its services and establish rehabilitation offices staffed by case managers and employment specialists in local communities as far as possible.

## Northern Ontario

70. That community–based regional rehabilitation facilities be established in Thunder Bay and Sudbury to provide rehabilitation services to injured workers in Northern Ontario, with:

    a) initial funding provided by the Workers' Compensation and Rehabilitation Board, and

b) that the Workers' Compensation and Rehabilitation Board purchase services on an appropriate fee–for–services basis.

71. That the Workers' Compensation and Rehabilitation Board case manager, in conjunction with the rehabilitation facilities, purchase rehabilitation services from the community.

72. That rehabilitation services be purchased as close as possible to the injured worker's residence.

73. That the Northeastern Ontario Injured Workers' Rehabilitation Program accept referrals from Workers' Compensation and Rehabilitation Board case managers.

74. That the community in Thunder Bay and the Northwest region, with an interest in the rehabilitation of injured workers, develop a rehabilitation facility, using the community-based model of the Injured Workers Rehabilitation Program for Northeastern Ontario as a guide.

75. That the Minister of Labour, in conjunction with the Minister of Northern Development and Mines, the Minister of Health and the Minister of Colleges and Universities, develop programs and incentives that will encourage and assist students of Northern Ontario to enter into education and training in the health care field in greater numbers and to seek employment in their field of study and profession in Northern Ontario.

76. That the Minister of Labour, in conjunction with the Ministers of Intergovernmental Affairs, Northern Development and Mines, and Health, undertake discussions with their Federal Government counterparts to provide the incentive for the possible migration of health care professionals who wish to practice in Northern Ontario.

## Non–Urban, Non–Industrial Sector

77. That the Workers' Compensation and Rehabilitation Board initiate a dialogue with representatives of Native bands to discuss the present rating schedule and rehabilitation needs of the community, taking into account such factors as the unique socioeconomic existence of Natives in Ontario.

78. That the Workers' Compensation and Rehabilitation Board initiate a dialogue with representatives of the agricultural community towards providing rehabilitation services that are relevant, accessible and appropriate for that community.

79. That the Director of Communications of the Workers' Compensation and Rehabilitation Board Rehabilitation Division develop channels of communication between the Workers' Compensation and Rehabilitation Board and the Native community and the agricultural sector, with the goal of establishing the following:

- a discussion of benefits and costs, and the potential usefulness of rehabilitation;
- clear and complete guidelines for undertaking coverage by the Workers' Compensation and Rehabilitation Board and making full use of its services and benefits;
- an outline of these services and benefits as they apply to Native people in urban, rural and remote settings, and to traditional and non–traditional forms of work;

80. That the Workers' Compensation and Rehabilitation Board identify other non–industrial and non–urban sectors or communities, such as the fishing industry and non–Native hunters and trappers in Ontario, and ensure that effective lines of communication exist or are established so that rehabilitation services to these sectors are relevant and effective.

## Review

81. That a re–evaluation be made on the targeting of safety dollars.

82. That rehabilitation be enshrined in the Act as Regulation 949 under the *Workers' Compensation Act*.

83. That a tripartite committee (labour, industry and government) be established to convert the Task Force recommendations into regulations.

84. That a tripartite committee (labour, industry and government) be established, either as a standing committee or otherwise, with the

power to make amendments, adjustments and recommendations to the regulations.

## Terms of References

1. To examine the vocational rehabilitation services provided by the Workers' Compensation Board, including an examination and identification of the goals and expected results of the vocational rehabilitation program.
2. To assess the adequacy of the funds expended by the Workers' Compensation Board on vocational rehabilitation programs in relation to the intended goals of the program and to other types of benefits provided to injured workers.
3. To explore strategies to identify, at the earliest possible opportunity, those injured workers who will probably encounter difficulties in returning to suitable employment, and to ensure that these workers are provided with appropriate vocational rehabilitation services.
4. To examine approaches for providing a comprehensive rehabilitation services to workers through the integration of vocational rehabilitation, claims and medical services.
5. To examine the role of vocational rehabilitation in facilitating the hiring of injured workers.
6. To explore the appropriate role for re–training and re–education in the vocational rehabilitation process.
7. To examine the extent to which the Workers' Compensation Board's vocational rehabilitation service is dependent upon vocational evaluations and to determine the role for the Board, the private sector and non–profit organizations in providing vocational evaluation services.
8. To consider any other vocational rehabilitation issues which the Task Force considers important.

## Introduction

The Ontario Task Force on the Vocational Rehabilitation Services of the Workers' Compensation Board (from now on referred to as the Task Force) was created on May 7, 1986, through an Order in Council and announced in the Legislative Assembly by the Honourable William Wrye, Ontario Minister of Labour, on May 14, 1986.

In his statement announcing the Task Force, the Minister justified its formation, citing the "continuing call by injured workers, legislators and rehabilitation professionals for extensive improvements to the vocational rehabilitation services of the Workers' Compensation Board."

This need had already been clearly identified by the Standing Committee on Resources Development in its 1984 Annual Report of the WCB:

> *An independent task force, comprised of representatives from labour, industry, and education should be established to make recommendations to the government and the Board regarding improvements in the rehabilitation system.*

Clearly, there was a need for reform within the rehabilitation process at the WCB. The question that remained was what should be changed and how should it be accomplished? This was the task presented to nine people representing labour, industry, education and the non–profit rehabilitation sector.

### Composition of Task Force

The Minister appointed two co–chairs to head the Task Force in a full–time capacity:

**Ms. Maria Minna**, Community Resources Consultant, Volunteer President of COSTI–IIAS Immigrant Services and former Director of the National Council of Welfare, and;

**Mr. Wally Majesky**, F.P. Labour Consultant Services, former President of the Metropolitan Labour Council and former Secretary–Treasurer of the Ontario Federation of Labour.

The other seven members are:

**Mr. John J. Corrigan**, Senior Claims Administrator and Rehabilitation Co–Ordinator of INCO Ltd., Ontario Division, Employee Benefits Compensation Office;

**Ms. Leonilde Delgado**, an injured worker, with experience in computer programming;

**Ms. Maxine Kewin**, former President of The Company Nurse, with experience on three Ontario Ministry of Labour Task Forces and a past member of the Joint Consultive Committee of the WCB;

**Dr. Clarence Sequeira**, Professor with the Department of Psychology at Ryerson Polytechnical Institute and a Clinical Psychologist in private practice, Toronto;

**Mr. Edward Thornton**, Administrator with L.I.U.N.A. Local 183, Training and Rehabilitation Centre Trust Fund, Director Building Industry Board;

**Mr. Peter Whiteley**, Executive Director of the Rehabilitation Division of Goodwill; and

**Mr. Bernie Young**, Treasurer and Compensation Officer of Local 6500 of the United Steelworkers of America, Sudbury.

## Informing the Community

Following the establishment of an office and staff at 2 Bloor Street West, Toronto, the Task Force set about the process of public consultation. It recognized the need to provide an opportunity to individuals and groups across the province to speak their minds and relate their experiences with the Board's rehabilitation services.

Over 20,000 invitations were sent to interested parties in industry, labour, the non–profit sector, community organizations, the legal profession, the health field, government agencies, as well as many other individuals and organizations. As a result, 201 submissions (see Appendix B) were received at the Task Force's office or in person at one of the public hearings.

## Public Hearings

The Task Force held 21 public hearings throughout the province in October, November and December 1986. The hearings were held in Thunder Bay, Sault Ste. Marie, Timmins, Elliot Lake, Sudbury, Kitchener, London, Sarnia, Windsor, Ottawa, Kingston, Peterborough, Oshawa, St. Catharines, Hamilton, Scarborough, Toronto, North York and Mississauga (see Appendix A).

At the request of the Italian–Canadian and Portuguese–Canadian Communities, two special events were also held in Toronto. Simultaneous translations were provided at these hearings so that the Portuguese and Italian communities in Toronto could speak to the Task Force members unhindered by language barriers. Although it took more time and planning, the Task Force felt it was imperative to hear from these two large communities, which have a history of employment in construction and other labour–intensive industries.

## The Public Hearing Experience

During its public hearing tour through the province, the Task Force came face to face with the severity of the situation that existed.

Time after time in every public hearing, representatives from industry, legal clinics, unions, health professionals and injured workers raised major concerns with the state of the Board's rehabilitation services. The anguish and personal suffering detailed by injured workers and their families which were raised were even more troubling.

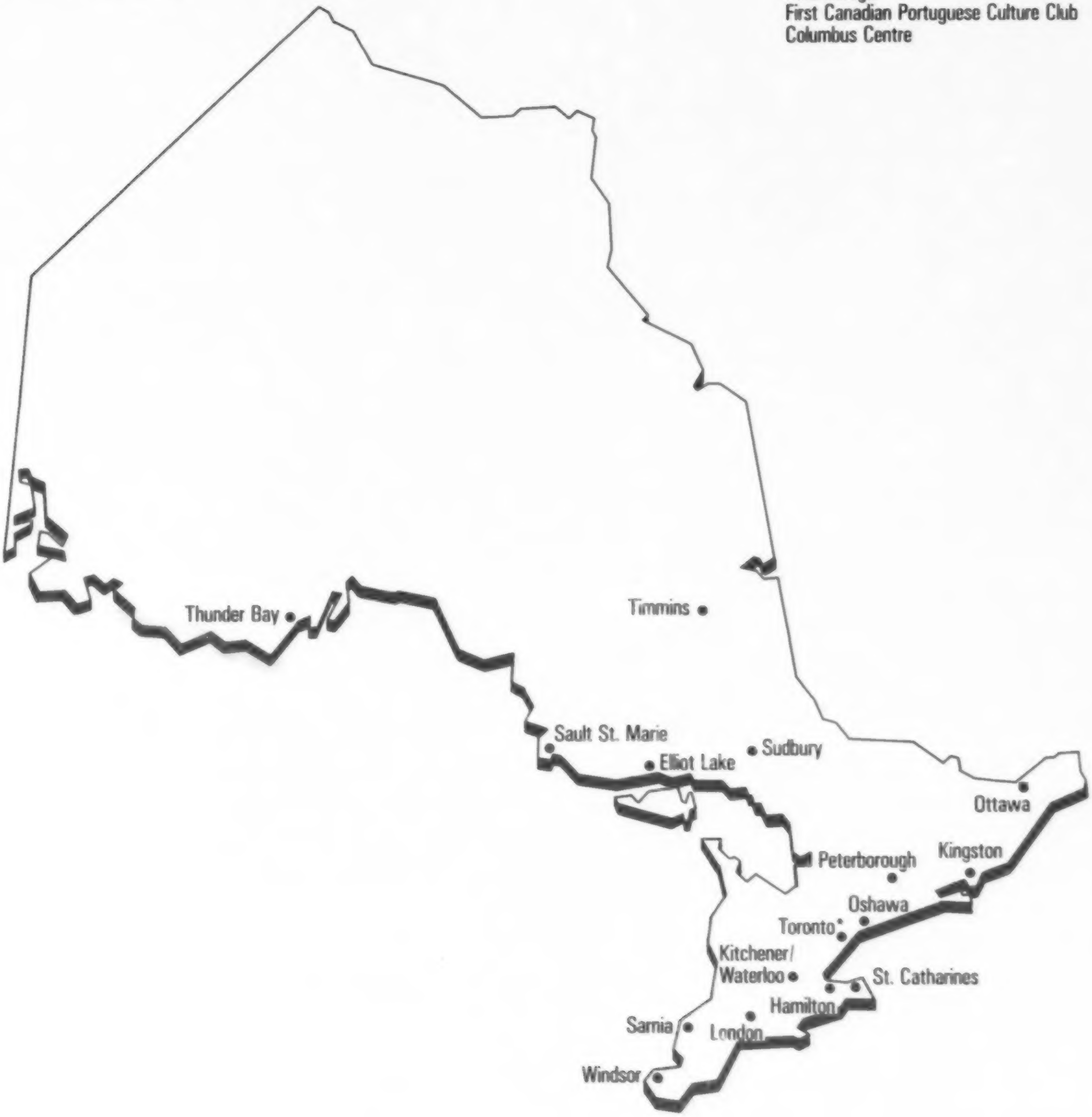
Naturally, the Task Force became a lightning rod for a host of complaints, not only about the Vocational Rehabilitation Division, but the WCB generally. As a result, the Task Force began to recognize the need for a holistic approach to the rehabilitation of the injured worker of which vocational rehabilitation was a major but not exclusive component.

## Advocacy Groups

Throughout the public hearings, the Task Force was impressed by the level of sophistication of the submissions presented by injured worker advocacy groups. The principal organization that advances the interests of injured workers as its sole objective to the WCB and the Ministry of Labour is the Union of Injured Workers.

## Location of Task Force Public Hearings

*Toronto
Scarborough
North York
Mississauga
First Canadian Portuguese Culture Club
Columbus Centre


Thunder Bay
Timmins
Sault St. Marie
Elliot Lake
Sudbury
Ottawa
Peterborough
Kingston
Oshawa
Toronto*
Kitchener/
Waterloo
St. Catharines
Hamilton
Sarnia
London
Windsor

However, there are several groups of injured workers across Ontario. In addition to representing their memberships at the political level (for example, holding demonstrations at Queen's Park), they provide peer counselling and paralegal advice to their members regarding their claims with the WCB.

While the Task Force recognizes the benefits that an advocacy group such as the Union of Injured Workers provides, it is unconvinced that funding should be provided by the WCB, given that the WCB is the focus of the union's criticism. A more appropriate source of funding would be the Ministry of Labour.

The Task Force, therefore, wishes to suggest to the Minister of Labour that he recognize the peer counselling and paralegal support provided by injured worker advocacy groups and explore the possibility of funding these organizations.

## CHAPTER 2

# The Injured Worker

- *profile of the injured worker*
- *some statistics*
- *characteristics of VRD clients*
- *the VRD experience*
- *VRD closures*

* * *

*...the first thing that must be remedied before any changes will be truly effective is the Board's seeming goal of stripping the injured workers of every vestige of dignity, self-respect and initiative...I think that we can appreciate what the injured worker has been through and is going through a very traumatic time and is plagued by fear and self-doubt as a result of what was after all an accident and not the result of choice. And the injured worker needs support and encouragement at a time like that, not ridicule. Although I accept that there are those who seek to abuse the system as people do in any system, the injured worker must be given the benefit of the doubt and be considered innocent until proven guilty.*

Clive Gordon
Injured Worker
Thunder Bay, October 20, 1986

* * *

*Lengthy periods of disability often result in serious financial difficulties (due to inadequate compensation, particularly those persons affected by ceilings), and severe alterations in lifestyle which impact on social and family situations. The experience of disability itself is generally a trauma affecting the worker and his entire family. Family problems, isolation from the work force and workplace associations have a negative effect on self-confidence and self-esteem.*

C.U.P.E., Local 1750
Scarborough, December 8, 1986

* * *

In the course of its investigations, the Task Force discovered that the WCB has gained an international reputation for quality of staff and service and has indeed accomplished a great deal for the majority of injured workers, in compensation, if not in rehabilitation.

But close inspection of the structure and process of the organization, through the studies commissioned by the Task Force, the submissions and the public hearings, revealed numerous problems. While complaints focused on the way compensation services were provided, many were also made of the rehabilitation service delivery. These complaints came not only from injured workers but also from rehabilitation counsellors, employers, unions, professional organizations and interested individuals.

The Task Force repeatedly noted that the process familiar to the injured worker was not the same as that portrayed in the publications of the WCB. There seemed to be a gap between the organizational structure in the form of its printed goals and objectives and the way these were actually translated into service delivery.

The procedures manuals indicate a broad band of available rehabilitation services that can be purchased by a rehabilitation counsellor. Yet this is not reflected in the service delivery process. Although counsellors stated in interviews they could purchase psychological assessment and psychosocial rehabilitation in the form of social work or psychiatric counselling, interviews with clients revealed this rarely happened.

One can speculate as to the reasons for these gaps. The Task Force attempted to pinpoint these through its open hearings, requests for written submissions and contracted research. On one hand, many of the responses heard consistently from injured workers in the community indicated that the attitudes of the WCB staff reflected an uncaring and adversarial approach to service delivery. On the other hand, staff would sometimes complain that injured workers failed to appreciate the complexities of a large organization, its hierarchies and procedural style.

It would be too glib to ascribe these gaps solely to the staff which is delivering the service, to say some counsellors are not as good as others, do not use the full range of services available and may not empathize fully with the injured workers. Some of this might be attributed to poor communications, ethnic and cultural differences between clients and staff or idiosyncrasies among clients and staff.

*But it became clear to the Task Force that the staff can only work within the constraints of the organization and their activities reflect the underlying, unspoken philosophy: a narrow* *definition of what should be offered, a begrudging attitude and a great concern with making the system look efficient on paper.*

Complaints voiced by the various segments of the population were personal and concerned with specific elements, yet all pointed to the inadequacies of an underlying model that had to be completely altered. A makeshift approach might silence some complaints but others would surely arise.

## Profile of the Injured Worker

The Task Force had two main sources of information concerning the relationship injured workers have with the WCB. The first came from the presentations made at public hearings by individual workers and advocates of injured workers, including the Union of Injured Workers, the labour movement, and legal clinics. The second emanated from a study based on a random sample of 120 injured workers who had received vocational rehabilitation services during 1985. Based on this data, the Task Force formed opinions, drew conclusions and made its recommendations.

Both sources of information presented a very similar picture. The public testimony presented by injured workers and their advocates was by no means representative of a small group of malcontents, but of the general situation which existed, as borne out by interviews with injured workers based on a random sample from WCB computer files.

As the Task Force convened 21 public hearings in its travels throughout Ontario in the fall of 1986, individual injured workers came forward and presented their personal case histories. No matter what town or region the injured workers came from, their stories were uniform in their description of neglect, humiliation, misery and appalling treatment at the hands of a public institution.

The Task Force was shocked by the extent of the mistreatment and the depth to which it had pervaded the entire province.

## Some Statistics

According to the Ontario Federation of Labour, nearly 1,000 Canadian workers are killed on the job each year. Over one million are injured, half of whom become permanently disabled. In other words, every six seconds of every working day a Canadian worker is injured. Every 12.7 seconds, a Canadian worker suffers a permanent disability. Every two hours one dies. Appalling figures and if the trend established in the 1970s continues, each year will get even worse.

The number of workers injured on the job and filing claims with the WCB of Ontario has fluctuated during the 1980s, reflecting the economic recession in the early part of this decade. As the economy has improved, however, there has been a corresponding increase in workplace injuries. In 1985, 426,880 claims were reported across Ontario, an increase of 9.8% over 1984, with a corresponding 9.6% increase in serious injuries resulting in lost time.

Most alarming perhaps are the marked increases in the proportion of high-percentage (50.1–99.9% disabled) permanent disability assessments to total awards over the past six years. (In 1985, awards in this category accounted for 34% of total awards granted, compared to 17% in 1981.) Preliminary figures for 1986 offer little hope for a reversal of this trend: total claims rose by 4% and lost-time injuries by 7.9% over the same time period in 1985.

Overall, Ontario statistics reflect a national trend of increases in numbers of disabling injuries, which have far exceeded the growth of the work force. According to a study of accident rates in the U.S. and Canada, these figures clearly demonstrate a rapidly deteriorating state of affairs in matters of work safety, despite the promises of the *Occupational Health and Safety Act*.

More than half of the allowed injury claims in 1985 resulted in no-lost-time, that is, the worker required medical treatment for his/her injury but was not off work beyond the day of the injury. Although the picture is less clear for degenerative conditions (e.g. back injuries), one can assume that in most of these cases the worker returned to the labour force with relatively little cost to him/herself or the system.

Of lost-time injuries, it is also the case that most workers return to their pre-accident employment with few apparent effects. Nevertheless, the phenomenal rise in serious lost-time injuries and substantial pension awards point to a large pool of workers for whom a smooth reintegration into the workforce is impossible.

There is no convenient statistic which can compute the number of individuals who would benefit from timely access to vocational rehabilitation services. In 1985, approximately six percent of lost-time claimants were deemed suitable for such service from the Vocational Rehabilitation Division (VRD). While VRD points with pride to a steady increase in referrals over the years, the six percent figure underscores the very low priority assigned to rehabilitation by the WCB, which allocated only 3.3% or $24 million of its 1986 budget for vocational rehabilitation services.

It is this 6% of workers who are the Task Force's primary concern. Who are the workers referred for vocational rehabilitation, how are they treated by the system, and what happens to them after "rehabilitation"?

## *Characteristics of Vocational Rehabilitation Division Clients*

An examination of available statistics and data gathered from interviews with injured workers reveals that many workers who are referred to the Vocational Rehabilitation Division (VRD) embody features most often associated with poor re-employment and rehabilitation outcomes. They are typically males in their mid-40s who have worked in labour-intensive bluecollar jobs.

While most workers are at least minimally conversant in English, many come from backgrounds in which English is a second language. Combined with relatively low educational levels, lack of fluency in English limits the worker's ability to understand the intricacies of the WCB bureaucratic machine. Limited education also results in few transferable job skills, limiting alternative employment options.

The majority of injured workers referred to the Vocational Rehabilitation Division have incurred a back injury, the type of problem which is frequently progressive rather than traumatic on onset and which is most likely to be regarded as "malingering". As a result of his/her injury, the worker is limited in bending, lifting, walking, sitting and prolonged or repetitive movements, eliminating any hope of returning to manual labour.

The disabilities endured by these workers are severe, long-term and intractable. Fifty-four percent of the interviewed sample received hospital treatment on the day of their injury; virtually all of these injured workers had seen at least one and often several specialists for their injury; 75.9% had been admitted to Downsview for assessment and/or treatment (nearly half of this group for more than six weeks). Sixty percent had undergone surgery; 88.4% had received physiotherapy. Thirty-two percent of interviewees were still actively receiving treatment while the length of treatment for the rest was about two years.

Of the 96% who reported receiving a permanent disability pension, 49% have been assessed at 10-19% disabled, 25% at 20 - 29% disabled, 9% at 30 - 39% disabled, and 17% at more than 40% disabled. Nearly all workers experience regular pain (between 6 and 7 on a 10-point scale) and are on medication to relieve discomfort, calm nerves and aid sleep.

Perhaps the most telling evidence for the severity of injuries sustained by this group is lost time. Thirty-five percent of the sample were off work following injury for at least three years, and the remaining 65% lost an average of 230 workdays. Seventy-four percent experienced a subsequent workplace injury, over half of which were reoccurrences or deteriorations of the original condition. The employment picture painted by the workers is one in which attempts to return to work are interrupted by periods of relapse and recovery, necessitating reopening of cases with the WCB, further medical treatment, pension reassessments and appeals, seemingly futile attempts to find suitable lighter work and subsequent unemployment.

Indeed, the employment statistics gathered in the Task Force's survey of injured workers attest to the extreme difficulties faced by this group in finding secure employment: 73% of workers interviewed were not working (although only 11% were then involved in training) and nearly 68% were receiving wage-loss benefits from WCB.

In comparison, Vocational Rehabilitation Division statistics report that fully half of case closures result from the injured worker's re-employment. However, because no longitudinal data is collected regarding duration of placement, the accuracy of this figure is questionable. The Vocational Rehabilitation Division does not keep records, for example, of how many injured workers remain employed after six months or a year. Unless the worker re-applies for VRD services, he is considered "rehabilitated".

The nature and extent of disablement suffered by this group suggest that alternative employment, such as part-time work, may best suit the disabled worker's present capabilities. A number of interviewees expressed a desire to work shorter and more flexible hours to accommodate their disabilities, but due to financial considerations were unable to.

An examination of pre- and post-accident hourly earnings from sources in the Vocational Rehabilitation Division demonstrates why this is so. Whereas only 22% of the 1986 closures were making less than $7.20 an hour before their accident, 41% were in this category after rehabilitation. The proportion of workers who had been earning more than $12.00 an hour before injury declined from 38% to 25.5% after rehabilitation.

Recognizing the likelihood of a substantial drop in wages pre- to post-injury, WCB provides a wage-loss supplement to employed workers to help make up this difference. The supplement is, in principle, available for up to three years, during which time the worker is optimistically anticipated to have regained lost financial ground. In practice, however, actual duration of the supplement is discretionary, and wage-loss benefits are usually terminated between six and 18 months. In any event, because the benefit is calculated on pre-accident earnings (regardless of wage-earning subsequent to the injury), workers rarely achieve their former earning capacity.

For many workers, these facts spell poverty: 10% report having been on welfare, and a further 82% say their standard of living has decreased somewhat or significantly. Although many are homeowners, 13% state they have lost a home as a result of injury and subsequent financial problems, and a further 26% indicate continuing uncertainty about living arrangements.

Statistics, however, cannot fully explain the effect of injury, pain and unemployment on security of living. Many workers are driven to take extreme measures to save family homes, and grown children, parents and other relatives may share living quarters and expenses to make ends meet. As a result of these alterations in lifestyle, many injured workers report considerable guilt and loss of self-esteem, as they are unable to "carry their weight" and support the family in their accustomed manner.

Clearly, prolonged unemployment contributes to a profound sense of worthlessness and hopelessness. Workers describe a pattern of increasing loss of motivation and self-absorption in which they gradually focus on their disabilities rather than their abilities. Concentration on pain replaces constructive problem-solving, as each worker takes on a "disabled role".

Financial and health concerns begin to dominate their outlook, and passivity, learned helplessness and depression become firmly entrenched as they wait for their doctors and counsellors to tell them what to do next. Seemingly endless confrontations with the WCB bureaucracy produce considerable anger and frustration.

Data concerning use of psychological services indicate that 17% of the interview group have or are presently receiving some type of counselling for problems they associate with their injuries and subsequent experiences, although in only a few cases does WCB recognize psychological problems as resulting from workplace injury.

Workers describe periods of alcohol and drug abuse, attempted suicide and family violence, which they link to financial pressures, mental distress and pain. Most workers report serious deteriorations in their relationships with spouses and children and great disruptions in their social networks. Despite often serious personal problems, however, injured workers rarely request help from the Vocational Rehabilitation Division for such matters, and when they do the system does not seem to "care".

## *The Vocational Rehabilitation Division Experience*

The goal of the Vocational Rehabilitation Division is to offer efficient and effective help to the injured worker. In practice, however, the provision of vocational rehabilitation services involves considerable time spent assessing each injured worker's eligibility for such services.

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> *The Board's vocational rehabilitation philosophy is to help injured workers return to the work force and the community as soon as possible.*
>
> Vocational Rehabilitation Services *Annual Report* 1985:4

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The initial determination of eligibility for access to the Vocational Rehabilitation Division is made by the claims adjudicator, a clerical position within the bureaucracy of the Claims Adjudication Branch. The claims adjudicator examines the medical assessment received from the worker's personal physician.

If it states that the worker is capable of "light" or "modified" work, the claims adjudicator determines if the accident employer has a job available for the injured worker. If the accident employer does not have employment available the worker will be considered for rehabilitation services.

If the injured worker is referred to the Vocational Rehabilitation Division, he is again screened for eligibility, this time by the rehabilitation services controller, a clerical position within the Vocational Rehabilitation Division. The worker is screened according to the same criteria as are applied by the claims adjudicator. This can mean a lengthy delay in benefits. Finally, if primary adjudication permits, the injured worker will be referred to a rehabilitation counsellor.

The counsellor's first decision is to determine whether the worker is "work ready" or "not work ready". The former category refers to those workers who apparently need no further training or treatment in order to get a job, and they constituted the majority (73.6%) of referral designations in 1985.

In other words, workers who have been referred to the Vocational Rehabilitation Division because they have been unable to return to work are informed that they are "work ready" and must look for a job! The logic of this designation is contradictory at best, especially considering that 21.6% of referrals to the Vocational Rehabilitation Division in 1985 were reopened cases rather than new referrals.

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> *We're Here to Help*
>
> *The Workers' Compensation Board has vocational rehabilitation services that can help you determine your capabilities and find work consistent with your aptitude and talents. We'll help your employer to modify your job or workplace, or train you in another job. And if that's not possible, we'll help to place you with a new employer. If necessary, we'll also help you to get training to prepare you for another occupation.*
>
> *Getting Back to Work: Help for the Injured Worker* (1986: WCB)

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Statistics from VRD sources and Task Force interviews indicate that typical VRD clients do not, in fact, come into contact with VRD counsellors for some 18 months following injury. During this lengthy period they have been encouraged by medical personnel to think of themselves as "sick" and their only contact with the WCB has been a twice-monthly cheque in the mail. When they are finally deemed to be ready for vocational rehabilitation, they are contacted and interviewed by a VRD counsellor who informs them that they are now expected to actively conduct a job search or establish some plan of vocational rehabilitation.

This may very likely be the first occasion since their injury that they have been asked to adopt the role of a healthy person, and they are understandably confused, apprehensive and skeptical about the prospect of finding a job. Their counsellors interpret their attitude as a lack of motivation or malingering, and threaten to cut off their benefits if they fail to "cooperate" in what appears to be a pointless exercise.

For the minority of VRD clients who are deemed "not job ready", the next step in the rehabilitation process is for the counsellor to establish, supposedly in collaboration with the worker, a rehabilitation plan. A wide range of assessment and retraining options is available to the counsellor, but in practice access to these services is largely discretionary and their expense only justified as a last resort.

In particularly intractable cases, for example, workers may be ordered to go to the Downsview Rehabilitation Centre (DRC). Uprooted from their family and community, confused, anxious and in pain, they nevertheless co-operate because they hope the doctors there can help them. To their surprise, however, the doctors and therapists are not interested in their problem — they seem only to want to prove that, despite what their specialists say and what they feel, the injured workers are fit for "modified" work and do not deserve further benefits.

Injured workers described to the Task Force the inhumane treatment they received at Downsview. They are forced to stand for hours in lines, to carry their luggage and make their own beds although they can barely walk. Nothing is explained to them; examinations are cursory at best; and the treatments leave them feeling worse rather than better. If they complain, or balk at treatment, they are accused of faking the extent of their disability. "It's all in your head," they are told. They know if they are labelled "uncooperative" they will lose their benefits. So they endure their humiliation and suffer in silence.

In a co-ordinated rehabilitation program, assessment would be the logical first step in determining the course of treatment or training. In reality, the purpose of assessments by DRC and WCB personnel is to limit entitlement to pensions and benefits, and access to further services from the Vocational Rehabilitation Division. Often the determination of "fit for light work" is in complete contradiction to the reports of the workers' specialists and surgeons who have examined them thoroughly and have worked closely with them throughout their recovery. Nevertheless, the opinion of WCB medical personnel is invariably the one which decides the workers' fate and often, in the opinion of WCB doctors, the majority are often fit for modified work.

Based on this assessment, workers looking for modified work are told to pound the pavement in search of elusive "light duty" jobs. The ideal work for them requires no lifting, bending or twisting, no repetitive movements and no prolonged sitting or standing. Where will 45-year-old disabled workers with less than high-school education find such work? Possibly their counsellors will find them jobs for minimum wages with companies with high turnover rates. The workers discover that so-called "light" work is more taxing than their original jobs. In any event, when the "training period" is over and the subsidies to the companies expire, the workers could lose even these marginal jobs.

In desperation, they look for jobs on the open market where they are forced to minimize or deny the extent of their disabilities in order to find employment. They take jobs which are now far beyond their physical capabilities, reinsure themselves, and once again the round of doctors, physiotherapy, pension reviews and Vocational Rehabilitation Division counselling begins.

At some point in this cycle, some workers may decide they have had enough. Although the compensation system was designed to eliminate the need for costly litigation, they discover they can cut through red tape much faster with a legal representative, MPP or other advocate on their side. They may finally get a chance for some real rehabilitation, perhaps some training or upgrading which can make them more competitive in the employment market.

But the reality is that less than a quarter of clients who go through the Vocational Rehabilitation Division will get training, and this figure has steadily declined over the past five years. Furthermore, a look at who is granted the rare privilege of training shows that those who need it most are least likely to receive it. The older, less–educated workers with limited skills and English fluency are told there is no help for them. They must go and find jobs.

Even when injured workers are given the opportunity to participate in training, they sense they lack any real input into decisions concerning their future. Workers who seriously desire retraining or education are denied the opportunity to pursue long–term goals to re–employment. Thrust into hastily considered training which do as not suit them physically or tempermentally, workers experience considerable stress because they know failure will mean curtailment of benefits and another ride on the endless compensation merry–go–round.

## *Vocational Rehabilitation Division Closures*

Typical workers who receive services from the Vocational Rehabilitation Division (VRD) spend most of their "rehabilitation" time looking for a job. According to VRD statistics, approximately 50% of cases are successful in this pursuit.

In 1986, 41% of VRD cases were closed for a variety of reasons and categorized under the heading "No Further Rehabilitation Action Indicated" (NFRAI). The title would suggest that for some reason these workers no longer need help. However, excluding those individuals who have recovered or died, fully 33% of VRD closures result from the counsellor's perception that the worker has been unco–operative.

For example, workers may refuse to take jobs that their specialists have determined are beyond their physical capacities. They may suffer emotional disabilities which the board refuses to regard as compensable, decline jobs they find demeaning, or refuse to relocate in order to take positions. Or, completely disgusted with the rehabilitation they have received, workers may simply refuse to deal with the Vocational Rehabilitation Division any longer.

Workers pay a high price for their perceived noncompliance. First, they remain unemployed. Then they are terminated from the Vocational Rehabilitation Division and benefits are either reduced by 50% or totally suspended. Injured workers have the right to appeal this decision if they wish, but this usually means lengthy waits if they have to go before hearings officers and further delays if the claims go to the WCAT. During this period the workers must live on either their pensions or social welfare.

Who are the workers most likely to fall into the NFRAI category? It is clear that they are the ones who are the least competitively employable and therefore most in need of rehabilitation. According to a Task Force study, they are the older, less–educated workers, employed in low–earning jobs prior to injury and now suffering from chronic or degenerative disabilities. They are the most likely individuals to return to the board again and again, who will cost the WCB and society more money in the long run because the board is designed to meet a bottom line, not to help those who need help most.

## Chapter 3

# The Workers' Compensation Board: Its Philosophy

- *an examination of philosophy*
- *the first principle*
- *the second principle*
- *the third principle*
- *the fourth principle*
- *injured workers' concerns*
- *counsellors' concerns*
- *employers' concerns*
- *purchase of service agency concerns*

* * *

> *WCB has taken away all of Louis' dignity and they have left him a broken man. The system on which the WCB operates does not take into consideration the total person. They only go by their 5%, 10% or 15%. And this must be changed, and each person be dealt with as an individual, not a part on which they place a price tag. Would the WCB expect a car to run with some of the parts working? I doubt it.*
>
> Mrs. Louis Blane
> Wife of Injured Worker
> Hamilton, December 3, 1986

* * *

> *We say that the WCB guidelines are responsible for the poor rehabilitation witnessed by the Task Force throughout the Ontario province. Even with the best recommendations of the Task Force, if these recommendations are not incorporated in the Act, nothing will move WCB to do a better job since nothing will give authority to the WCAT (Workers' Compensation Appeals Tribunal) to revise decisions based on such guidelines permitted by* Section 54 *and based on necessity or expedient criteria!*
>
> United Steelworkers of America,
> District 6
> North York, December 11, 1986

* * *

The *Workers' Compensation Act* was enacted in 1914 to provide a "no-fault" insurance scheme of financial compensation that would save injured workers and employers litigation costs offset by premiums paid by the employers. As long as the premiums were less than the feared legal costs, things ran smoothly.

But since 1914 premium costs have continued to rise rapidly and workers began to realize that, as an insurance scheme, the Act disallowed their suing for suffering and non-debilitating pain. It became apparent that the nature and extent of rehabilitation services were restricted to restoring employability and controlling the costs of running the WCB. Very little rehabilitation was offered that would reconstitute a life damaged by an accident for which no fault was assessed — a life where functional, social and economic independence may have been lost.

The WCB, caught between the hammer of the growing power of the workers and the anvil of resentment by employers toward rising costs, has scurried about looking for measures that would reduce this rise of costs such as the proposed early intervention, integrated service units and vocational evaluation centres.

The Task Force was established to examine the inadequacies of the system. But, moving through the province and receiving deputations from all segments of the population, it soon began to realize that efficiency is less important than effectiveness, that human life, dignity and emotional stability will not only make for more satisfied workers, but will save money for the employers in the long run.

The Task Force became aware that employers must become more concerned with occupational health and safety to forestall accidents and their expensive outcomes, with job reinstatement and job modification to return the worker to the workplace and with the general welfare and satisfaction of the labour force in Ontario.

The Task Force also believes that the Government of Ontario is obligated to provide financial support to its working citizens, especially if they are injured at the workplace or contract an occupational disease. However, as it presently stands, when these workers are unable to get assistance from the WCB, they are forced to go to other social service agencies, which may not be able to serve their needs as adequately.

Finally, the Task Force recognizes that the WCB must alter its purpose and goals from one that reacts to the pounding of the hammer on the anvil to one in which it takes a proactive role to ensure the best and most holistic rehabilitation.

## An Examination of Philosophy

The establishment of the Workers' Compensation Board in Ontario in 1914 achieved a giant milestone in Ontario's history.

It established the fact that workers injured at work had rights to compensation and its main goal was to restore them to employability. It meant that under some circumstances, injured workers could receive rehabilitation services that would help them get a job.

Over the almost 75 years since the board's inception, the total number of injured workers who received service from the board has passed the 10-million mark. But the number of injured workers who received rehabilitation services over the years has always been quite minimal. The following table shows the percentage of clients referred to vocational rehabilitation services compared to the number of total and allowed lost-time claims.

Surely one must acknowledge that number is astonishingly small.

It would be impossible to determine the extent to which referrals to rehabilitation fall short of those that require rehabilitation services. To do that, one must first determine the WCB's rehabilitation goals and philosophy, the process by which referrals are made, the way these services are provided and the extent to which workers may request and receive rehabilitation.

The hearings across the province identified injured workers who clearly could have gained from the receipt of rehabilitation services, not only medical and vocational, but services directed at restoring their dignity and quality of life.

According to WCB statistics, rehabilitation services seem to have been effective and appreciated in the main. But the sheer number of complaints heard throughout the province opens a Pandora's Box of whether the statistics recognize the reality of thousands of people who have been injured at work and for whom the system has failed.

It is in the name of these people that the WCB must be judged and for whom changes must be introduced. It is not enough to point to the success of an organization; one must also examine its failures and weaknesses. To indicate that a majority of people have gained from WCB services is also to recognize that a minority failed to obtain the benefits due them.

A number of things can be perceived readily. The WCB still has a pre-WWI mentality about the nature and goals of rehabilitation and is generations away from the concept of rehabilitation espoused in the eighties. At least part of the blame for this attitude must be laid at the feet of a succession of provincial governments. There is no disciplinary body that certifies rehabilitation service delivery on the basis of quality and no school training rehabilitation counsellors at the graduate level in Ontario. But most of all, there is no acceptance of the fact that the disabled are entitled to receive the best treatment the province can afford, whether they can be re-employed or not.

The WCB is driving a 1914 model of rehabilitation.

There is no question that there are millions of Ontario citizens who are thankful for the existence of the WCB. But there is also no question that there is a great deal of frustration and unhappiness with the organization. Undoubtedly, there would be less dissatisfaction if injured workers and employers knew what rehabilitation services were available and that Ontario would service them in the way they deserve as citizens and workers who have contributed to the development of the province.

**Percentage of Clients Referred to Vocational Rehabilitation**

| | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 |
|---|---|---|---|---|---|---|---|
| % of total claims | 1.3 | 1.6 | 2.2 | 2.4 | 2.0 | 2.6 | 2.6 |
| % of allowed lost-time claims | 3.5 | 4.0 | 5.1 | 5.5 | 4.4 | 6.0 | 5.9 |

The Task Force has spent almost a year receiving briefs, meeting groups and talking to people in all walks of life. It has commissioned a number of studies of rehabilitation service delivery in other provinces and countries and has investigated elements of the service delivery model that is practiced at the WCB.

Much of the information that has been assembled from these diverse sources is consonant with many aspects of the model that is practiced at present. Over the past 75 years, this model has undergone several changes in compensation but very few in the area of rehabilitation. It is primarily a financial insurance scheme with little concern for the individual except as an employee who is not at work. Concepts of rehabilitation held before the First World War are still prevalent in Ontario despite society's conceptualization of, and attitude towards disabilities, shifting from the impact of the traumatic event towards a better understanding of its effects.

The response of those who wrote or spoke to the Task Force made it clear that any change in service delivery at the WCB must be more than a superficial band-aid treatment. Rather, the whole model and underlying principles must be restructured. It became obvious that alterations in the job description of a counsellor or the location of desks in offices at 2 Bloor St. East would not affect the fundamental nature of the program.

Since the creation of the Task Force in 1986, the WCB has instituted internal task forces, hastened policy changes and proposed a number of alterations in its service delivery. While there is no evidence that these changes were instigated by expected criticism from this Task Force, it has become apparent that the haste in developing the new thrusts is meant to confuse the very public the WCB is directed to serve.

During its deliberations, the Task Force failed to receive the WCB's complete co-operation and had difficulty obtaining information that might aid in making its recommendations. This adversarial approach meant the Task Force was somewhat limited in its investigation of WCB procedures, outcome data from its activities and plans for improvements in its service delivery model.

Of course, not everyone at the WCB deliberately caused problems for the Task Force but enough did to make its task even more difficult than it was. Despite these efforts, it obtained more than adequate information for an honest appraisal of the structure and process of the WCB.

There seem to be two different philosophies in the WCB today. Reading the printed material, one gets a picture of a caring yet efficient organization. The Vocational Rehabilitation Department expresses its philosophy as:

1. a belief in a total (person) concept
2. a goal-oriented program
3. one that invites full participation of the injured worker

It is difficult to find fault with such statements except that they are vague and undefined. There is no explanation of what a "total (person) concept" is, nor can one imagine a non-goal-oriented program. Most of all one is left to wonder what full participation by the injured worker can mean. Does the injured worker have the power to refuse a counsellor-imposed rehabilitation program without penalty? Does full participation mean any more than that the injured worker is expected to accept whatever the claims adjudicator allots as benefits?

This expression of the WCB's philosophy is vague and open to many interpretations by the staff. It therefore becomes important to examine not the printed principles that are there for all to read but the underlying principles that truly direct the actions of the staff. By looking at what the Board does, as opposed to what it says, one can find out what the administrative staff really believes and how rehabilitation counsellors are moulded into their jobs.

These underlying principles shape how the *Workers' Compensation Act* is interpreted, especially in Section 54 dealing with rehabilitation. The administration puts pressure on the counsellors to perform their jobs in ways that will bring them job satisfaction and promotions. They affect the type and quality of service extended to injured workers and their relationships with employers.

Now these basic precepts have been brought to the light of day and laid out for examination. It is not the overt, printed philosophy that is to be judged, but the principles that really drive the system.

When the Task Force discovered the directions of some of the changes proposed and instituted by the WCB, it was astonished at the lack of insight into the fundamental problems inherent in the organization. It is as if communications at the WCB is one way — telling the world about its achievements, but ignoring the concerns of the people who receive the services, or even those of its own front-line staff who deliver them.

All the changes proposed by the WCB are cosmetic — designed to make the system more efficient, but not more effective. While the board has developed Integrated Service Units to make communications easier, it does not focus on the essentials that are to be communicated. Moreover, the $1.25 million Vocational Evaluation Centres proposed in the board's *New Directions in Vocational Rehabilitation* plan will be no more effective than the service provided by the Downsview Rehabilitation Centre (DRC), service the Downsview Review Team found to be very poor. Band-aid solutions and moving personnel into new offices with new titles will not significantly improve the organization.

Change must be radical and must start with replacing the underlying principles that drive the present system. Only through the introduction of new guidelines can the WCB and its clients effect a better relationship. Of course the WCB does not openly profess these principles and if challenged would reject them as untrue and unsubstantiated.

However, these basic precepts are quite evident after a thorough analysis of the *Workers' Compensation Act*, the board's structure, staff actions and complaints of the workers, employers and professional agencies that interact with the WCB. Close scrutiny of the messages unconsciously transmitted by words and deeds shows that these four principles drive the model practiced today.

## *The First Principle*

The first principle deals with the fundamental relationship between the board and the injured workers:

> *Rehabilitation services to workers injured on the job in Ontario are offered only as a last resort.*

The *Workers' Compensation Act* of Ontario, first passed in 1914, last revised in 1980 and amended since then a number of times, is clearly an insurance scheme whose primary focus is financial compensation. Rehabilitation is treated merely as a supplementary service offered at the Board's discretion and directed solely towards re-employment.

There are 142 sections in the Act. Section 54 is relegated to a weak, nine lines of vague indecisiveness reflecting the disinterest of the government and society of the early twentieth century. The Act stresses the economic commitment of that government to financial compensation and Acute Health Care and emphasizes that the WCB's purpose is to foster the worker's return to the job at minimal cost. In 1914, this may have been acceptable. But by the time of the latest 1980 revision, most of the western world was concerned with the injured worker, not simply as a cog in an industrial wheel but as a human being. Unfortunately, this recognition was not reflected in the most recent amendment.

The 1980 revision took place in the shadow of the Year of the Disabled in 1981 and, despite the publicity and media pressures of that year, the Ontario government seemed to have felt no impact.

In 1981 a report of a Special Committee on the Disabled and the Handicapped of the Government of Canada, entitled *Obstacles*, set forth the following objectives:

- achievement of adequate income
- support for promotion of self-help efforts

- provision of technical aids, and community support services such as attendant care and intervenor services
- equal benefits and protection under the law
- equal opportunity of access to public buildings, facilities and programs
- equal access to a full range of opportunities in:
- employment
- housing
- education
- transportation
- recreation
- communication and information
- provision of community support services to reduce or eliminate the need for institutional care
- improved quality of life for disabled persons who live in institutions

But in Ontario, the government of that time was oblivious to the thrust of *Obstacles* and the Year of the Disabled. Amendments to the rest of the Act were made almost every year but no substantial changes were made to Section 54.

The part of Section 54 that reflects that attitude of rehabilitation as a last resort lies in the following statement:

> *... the Board* **may** *take such measures and make such expenditures as it* **may** *deem necessary or expedient.* (emphasis added)

This attitude leads to inequality of treatment delivery and vulnerability of the staff to external pressure and internal prejudices. Rehabilitation is offered to injured workers by adjudicators who interpret a set of vague criteria based on grudging acceptance of the need to offer them rehabilitation services.

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> *The enabling section of the* Workers' Compensation Act, *Section 54, is entirely discretionary. It does not* obligate *either the Workers' Compensation Board or the accident employer to take any action. In content, it appears to be no more than a token gesture paying lip service to the idea of Board involvement "in getting injured workers back to work". This section has no teeth.*
>
> Niagara North Community Legal Assistance
> St. Catharines, December 2, 1986

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The Task Force discovered that decisions to extend rehabilitation services are generally made when there are overt signs of disablement (i.e. *visible injuries*), through expressed demands from the injured workers through their lawyers, by political fiat, or by instructions from physicians.

Even though the Act professes to be a "no-fault" insurance scheme, there is an underlying current that pins guilt on the injured worker for having had the accident and this contributes to the determination of whether rehabilitation services will be offered. The no fault basis of our workers' compensation system implies that workers are not to blame for their accidents, injuries or disabling conditions. Section 3(3) of the *Workers' Compensation Act* presumes that where the accident arose out of the employment, unless the contrary is shown, it shall be presumed that it occurred in the course of the employment and, where the accident occurred in the course of the employment unless the contrary is shown, it shall be presumed that it arose out of the employment.

This, theoretically, places the onus on the employer or the board to prove that the accident did not occur at the workplace. In practice, however, the worker is usually challenged to prove that the accident did, in fact, arise out of the job.

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> *... there is a tendency to see injured workers as the authors of their own misfortune, and therefore, deserving of no more than minimal benefits.*
>
> Ontario Federation of Labour
> Mississauga, December 12, 1986

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Because of this unquestioning acceptance of culpability, and possibly because of the need to keep costs to a minimum, injured workers are often seen as undeserving of rehabilitation.

* * *

> *First there must be a basic change in the philosophy of accident causation that addresses the "unsafe conditions". This will then alter the attitude towards the injured worker who becomes a victim of "unsafe conditions" and not the cause. This means that every injured worker, then, deserves adequate compensation, meaningful rehabilitation programs and the right to return to work...*
>
> *To reflect this philosophical change, we believe that the discretion present in Section 54 of the* Workers' Compensation Act *must be removed, and the Board shall be required to provide rehabilitation programs to any injured worker.*
>
> Ontario Federation of Labour
> Mississauga, December 12, 1986

* * *

This emphasis on saving money puts pressure on medical personnel and rehabilitation counsellors to severely limit rehabilitation services to the injured workers. It promotes an adversarial relationship between those injured workers who sense they must fight for what they should receive and the WCB staff who are afraid that the injured workers will exploit the system. In fact many of the workers who don't fight fail to get rehabilitation services altogether.

This adversarial process is reflected in expensive court costs, repeated referrals to medical personnel for additional opinions, unnecessary vocational and work assessment, and frustration and anger on the part of the injured workers.

The Task Force feels that in the long term, the struggle to keep expenses down may be offset by the financial and time-consuming costs of litigation, constant referrals for assessment and work overload on the rehabilitation counsellors.

## *The Second Principle*

The second underlying principle that drives the present system deals with the way rehabilitation is defined.

> *The definition of rehabilitation is restricted to medical and vocational rehabilitation.*

Section 54 of the Act states that part of the mission of rehabilitation is

> *to aid in getting injured workers back to work and to assist in lessening or removing any handicap resulting from their injuries.*

Yet its interpretation is made as narrow as possible, and the service is restricted to a reduction or removal of any functional disablement that will help the injured worker return to work. In fact, apart from medical rehabilitation, the Vocational Rehabilitation Services Division (as its name suggests) clearly restricts its mandate to vocational and prevocational services, offered at the discretion of the rehabilitation counsellors.

Assessment and treatment of the emotional impact of an injury is generally by referral from a physician when it is too obvious to be denied or by a rehabilitation counsellor who may or may not have been trained to recognize the need for such services.

The term "handicap", referred to in the Act, is also interpreted in its narrowest sense, in opposition to its definition by the World Health Organization.

* * *

> *Handicap: a disadvantage for a given individual, resulting from an impairment or a disability that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual.*
>
> World Health Organization
> Geneva, 1980

* * *

This definition follows the philosophy that rehabilitation is holistic and directed to the restoration of independence in all aspects of an injured worker's life.

In 1987, it is universally recognized that every physical trauma carries with it an emotional impact. Again and again the Task Force was confronted with the facts that problems of rehabilitation service delivery were fewer when visible injuries were encountered but assessment and treatment become prolonged and complex when the injuries carried with them emotional components. Moreover, where visible injuries were neglected, invisible components of these injuries got worse.

The assessment and treatment of invisible injuries appear to create the greatest difficulty and lead to complaints of unfairness by the injured workers. These invisible injuries include physical disablements that are not readily identified by objective methods, such as migraine or lower back pain and psychological/sociological handicaps that result from the emotional trauma of injuries. They must be recognized and treated for their effect on injured workers, as the emotional traumas are just as great as the physical injuries.

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*The actual experience of pain as a result of any particular injury is, therefore, now acknowledged to vary from individual to individual. It is also recognized that in the same individual the same pain stimuli will produce markedly different pain experiences depending on the psychological environment.*

Workers' Compensation Appeals Tribunal,
Decision No. 915
May, 1987

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In the last decade, the emphasis in rehabilitation has shifted from physical and vocational rehabilitation to the reduction of disadvantages in all areas of life that result from an injury.

In an excellent exposition by one of the foremost American writers in rehabilitation today, Wright begins his book with a description of rehabilitation:

> *Rehabilitation is a facilitative process enabling a person with a handicap to attain usefulness and satisfaction in life....Rehabilitation then equalizes opportunity for life attainments as a human right and societal obligation.*

The Task Force accepts this quote as a principle and recognizes its implications: first, that rehabilitation is a human right; second, that society is obligated to provide it; and third, that rehabilitation is more than medical and vocational. The mandate of rehabilitation is to attain usefulness and satisfaction in life.

The members of the special committee that wrote the *Obstacles* report, after examining these obstacles in detail, stated that the following principles should be embraced by all Canadians:

- **Participation**: Disabled Canadians must have the same opportunity to participate fully in all of the educational, employment, consumer, recreational, community and domestic activities which characterize everyday Canadian society.
- **Responsibility**: All Canadians are responsible for the necessary changes which will give disabled persons the same choice of participation that are enjoyed by those who are not disabled.
- **Self-Help**: Disabled Canadians are often best able to help themselves through their own service and advocacy organizations.

Other jurisdictions, such as Quebec, Sweden and the Netherlands, have recognized the rights of the injured worker to rehabilitation following a traumatic event or a debilitating industrial disease. Moreover, they have realized that rehabilitation is far more than only the restoration of physical function and referral to a job. The Quebec Act, which deals with industrial accidents and occupational diseases, states:

> *A worker who, as result of the employment injury he has suffered, sustains permanent*

> *physical or mental impairment is entitled, to the extent provided by this chapter, to the rehabilitation required by his condition in view of his social and professional reintegration.*

The World Health Organization, the International Labour Organization and Rehabilitation International have all defined rehabilitation in a manner which is more encompassing in its regard for the welfare of an individual.

Rehabilitation International, in its 1981 *Charter for the 80s*, defined rehabilitation or habilitation as:

> *a process in which the combined and coordinated use of medical, social, educational and vocational measures assess individuals with disabilities to achieve the highest possible level of functioning and to integrate within society. Rehabilitation measures directed towards improvement of function and to enhance the quality of life include:*

- *medical care and treatment;*
- *therapeutic measures such as those provided by physical therapists, occupational therapists, speech therapists, psychologists and others;*
- *training in self-care activities including mobility, communication and daily living skills with special provisions as needed for the hearing impaired, the visually handicapped and the mentally retarded;*
- *provision of technical aids and other assistive devices, prostheses and orthoses;*
- *education;*
- *vocational assessment, training and placement;*
- *social counselling and assistance*

The Task Force has followed these internationally accepted definitions of rehabilitation and therefore defines rehabilitation as:

> *the process of restoration of persons who are injured, or suffer a debilitating disease on the job, to the fullest physical, mental, social, vocational and economic usefulness to the maximum possible extent.*

Clearly the nature of the process has become holistic and it is impossible to regard rehabilitation as being anything less than the restoration of an individual the maximum possible extent.

The underlying principle that drives rehabilitation is one that restricts it to medical and vocational areas and is directed solely to the reinstatement of a worker at the job. As long as this continues, the determination of employability will remain the responsibility of medical personnel, one that is not really in their field of expertise and one they are frequently reluctant to accept.

## The Third Principle

The third underlying principle that appears to drive the present model is concerned with the goals and objectives of the WCB.

> *Only job placement is acceptable as a successful outcome of rehabilitation.*

In a society in which the work ethic is dominant, all adults are expected to work or look actively for a job. Those who don't are considered by that society to be either sick or malingerers.

This tenet seems to be demonstrated at the WCB by staff attitudes to workers with invisible injuries. There is a subtle denigration of injured workers who aren't eager to return to work, which arises because the staff interprets the lack of motivation as an unwillingness, rather than an emotional barrier to readopt a worker role. The principle that rehabilitation is a privilege rather than a right makes this negative interpretation even worse. Some counsellors only offer psychosocial rehabilitation when they expect it may lead to placement, while others, who empathize with the needs of the handicapped workers to become independent, undermine the system to offer them caring service.

Compare this attitude to the one displayed by the Quebec Act.

> *To ensure the worker's right to rehabilitation, the Commission shall prepare and implement, with the worker's collaboration, a personal rehabilitation program, which may include, according to the worker's needs, a physical, social, and professional rehabilitation program.*

A primary method used to motivate injured workers back to work is the threat of denying them financial compensation. Some rehabilitation counsellors may not appreciate the barriers that exist towards re-employment and view the client with invisible injuries as not wanting to return to work. Pressures on rehabilitation counsellors come from an administration which stresses an accounting of "successful closures" (i.e., placed in jobs) and by injured workers for whom financial compensation may be reduced or cut off if they are unable to return to work.

Because job placement is the only acceptable outcome, rehabilitation counsellors are really vocational counsellors and receive little training in the evaluation of the mental and social impact of a traumatic event. When clients, who are reported by medical rehabilitation to "be fit for light, modified work", balk at placement in meaningless jobs or inappropriate work that may lead to reinjury, some counsellors lack the insight to search for both the internal and external barriers that militate against reemployment. The Task Force is greatly concerned with the conflict that arises in such situations and has studied the barriers to reemployment carefully.

## The Fourth Principle

The fourth principle that drives the WCB deals with the relationship of the administration to its staff.

> *Paper work is more important than people work.*

Many organizations become preoccupied with administrative competence to the point where they lose sight of their mission. They become more concerned with reporting functions, such as bookkeeping, statistics and annual reports, than with the services they were meant to perform.

Organizations which are top heavy with administrators who promote efficiency get carried away with the drive towards displaying themselves in a good light. When these organizations have, as their front-line personnel, undervalued workers who can be manipulated, the workers either line up with the administration or rebel and try to undermine the process.

Human service organizations are especially vulnerable to the paper work syndrome. The model of an industrial company that produces a large number of identical objects cannot be adapted easily into human services operations. Rehabilitation must be based on the uniqueness of the individual and the development of customized programs for each problem. Tracking the size of a case load, the mileage travelled or the number of telephone calls made per day may make for interesting statistics and reports, but they contribute nothing to the quality of health service delivery.

Throughout the months of the Task Force's work, the implications of these principles were revealed in complaints that counsellors were overworked and dissatisfied, injured workers had not been contacted for months and statistics were manipulated to show that many clients were receiving a great deal of service.

The translation of this fourth principle into action has a number of results. Clients who are not compliant are rejected. Services that are difficult to organize and deliver are avoided. Clients may not be referred for rehabilitation services until pressure is brought to bear. Staff chafe with a reported 40% of their time spent at paper work. And follow-up services for clients whose files have been closed are not performed.

The Task Force has concluded that these four principles underlie much of the antagonism and confrontation among the various sectors of society and the Workers' Compensation Board. Although rarely voiced in these terms, the problems raised by the community are undeniably serious.

## *Injured Workers' Concerns*

The following are some of the major concerns voiced by the 120 injured workers interviewed by a Task Force research team.

| | **Percent voicing concern** |
|---|---|
| **1. Financial Security** | |
| – cheques late, erratic | 37 |
| – benefits/pension too low | 28 |
| – cut off without explanation | 19 |
| **2. Adversarial nature of the system** | |
| – treated like a liar/bum/criminal | 35 |
| – unless you fight you don't get anywhere | 25 |
| – need legal representation to get results | 22 |
| – need to keep extensive documentation | 16 |
| **3. Communication with WCB and Vocational Rehabilitation Division** | |
| – too much red tape, run around | 33 |
| – rights, benefits not adequately explained | 23 |
| – conflict between specialists and WCB physicians | 22 |
| – internal communication problems | 8 |
| **4. Psychosocial aspects** | |
| – feel helpless, hopeless, no sense of self-determination | 24 |
| – receive psychological/psychiatric help for problems associated with unemployment, pain, and poverty | 17 |
| – want training | 15 |
| **5. Unfeeling bureaucracy** | |
| – counsellors don't understand pain, disability | 18 |
| – just get a job, any job | 18 |
| – treated like a number | 17 |
| – nobody seems to care | 13 |
| – counsellors not trained to help with psychosocial problems | 12 |
| – pushed too hard | 11 |
| **6. Employment** | |
| – won't be hired if employer knows of injured worker's association with WCB | 13 |
| – WCB being "ripped off" by companies | 10 |
| – more emphasis on re-employment with accident employer | 10 |
| – counsellors need more knowledge of workplace | 6 |

## *Counsellor Concerns*

Private interviews with 50 counsellors revealed that caseload size was their main concern.

| | **Percent voicing concern** |
|---|---|
| **1. Caseload size** | |
| – reduce and/or cap caseload | 76 |
| **2. Evaluation criteria used by supervisors** | |
| – do not focus on counselling skills (focus on quantity not quality of service) | 50 |
| – standards and guidelines not sufficiently realistic | 18 |
| – too much emphasis on paperwork | 10 |
| – more flexibility needed in standards | 8 |
| – insufficient feedback from agencies and employers | 6 |
| **3. Vocational Rehabilitation Services Eligibility** | |
| – restrict eligibility for *some* clients who are in and out of the system for as much as 10 years or when it should be a UIC issue | 46 |
| – vocational rehabilitation services should be more available | 20 |
| – too much political interference | 12 |
| – no change | 26 |
| **4. Claims and Medical Issues** | |
| – need for more rehabilitation education for claims staff | 70 |
| – inadequate communication with claims division | 55 |
| – inadequate communication with medical division | 48 |
| – need for more rehabilitation education for medical staff | 24 |

## *Employer Concerns*

Employers who submitted briefs also had some common problems with the present system.

- continually increasing cost of service
- undue delays in intervention by rehabilitation services
- level of rehabilitation services is inadequate for their needs
- some injured workers take advantage of the system
- the board is unwilling to invest money for modifications of job site
- counsellors' case loads are too large
- fear of being responsible if a worker who had been previously injured with another employer has a reoccurrence of the injury at work
- bureaucratic attitude inhibits communications between rehabilitation staff and the company
- centralization of services at Downsview Rehabilitation Centre
- need for an independent non-profit agency to objectively assess abilities

## *Purchase of Service Agencies Concerns*

The research team sent a questionnaire to 28 agencies that supply work assessment and adjustment training services to WCB clients and were told the following:

- clients from WCB seen to be older and somewhat less-educated than the average agency clients
- unspecified back pain, a very difficult problem to treat, is the most common presenting condition
- literacy problems are frequent
- clients from WCB are more frustrated, angry and less enthusiastic than those from other sources
- clients are sent to agencies after long delays
- there is a feeling that some clients are referred to agencies so they can find reasons to cut them off benefits. This may be true of the more difficult to place, such as older workers and new immigrants

## CHAPTER 4

# Workers' Compensation and Rehabilitation Board: Its Philosophy

- *principles*
- *mission statement*
- *structure*
- *some important changes*
- *organization chart*

* * *

> *I started looking into it and I was reading all the preambles that are before the rehabilitation program. I wonder if the counsellors have ever read the preambles, the background and definitions, the goals? Things that relate to the whole person. Our goal is* the *job for* the *person and the word "the" is underlined.*
>
> Mr. Rod Noel
> Injured Worker
> Scarborough, December 8, 1986

* * *

> *Counsellors have slipped into a conflict of interest with their clients because the administration's priority and policies are to ensure that people move off WCB. It seems that counsellors keep asking, "How quickly can we cut this worker off?"*
>
> Mr. James Clancy, President
> Ontario Public Service Employees Union
> Mississauga, December 12, 1986

* * *

Clearly the principles underlying the present structure and process must be altered if any significant change is to be made. New principles must be established that reflect a more caring attitude towards, and empathy for, people who are injured on the job or contract an occupation-related disease. The value of human life must be respected and the preservation of an individual's dignity and quality of life must be at the core of our treatment of injured workers in Ontario.

## Principles

The Task Force has therefore adopted a new set of principles that will guide a model of rehabilitation that will reflect these attitudes.

1. A definition of rehabilitation that, in concert with the World Health Organization, recognizes the wholeness of the individual — physical, mental, social, vocational and economic.
2. Rehabilitation must be the right of an injured worker, not a last resort. No longer can there be a subtle search for exclusion of service, but, regardless of the cause and type of work-related disability, the injured worker should be offered full rehabilitation services.
3. While re-employment is the favoured outcome of rehabilitation, it must not be the only measure of success. Success is not to be counted only in terms of vocational independence, but must include social and economic independence and emotional stability.
4. The responsible agent for the rehabilitation process must be a rehabilitation counsellor who, in partnership with the injured worker and in concert with others, manages the entire rehabilitation process. Employers, injured workers and anyone having dealings with rehabilitation services must be able to identify the individual responsible for the service delivery quickly and easily.
5. Rehabilitation must be separated from compensation in the minds of the injured workers, the counsellors, the employers and the organizations and individuals from whom rehabilitation services are purchased. Rehabilitation must be given a high profile that can reflect its importance.
6. Reinstatement at the old job, whenever possible, must be the right of an injured worker. Where this is impossible, workplace modification, retraining and relocation services must be offered as close to the pre-injury job in content, income and location as possible.
7. Injured workers who cannot return to their employment and cannot find satisfying work should not be rejected but should be helped to live a life of dignity.

The Task Force has therefore embodied these principles in a mission statement for a new Workers' Compensation and Rehabilitation Board.

## Mission Statement

1. The Workers' Compensation and Rehabilitation Board is committed to the concept that workers injured at the workplace must have the opportunity to restore their competence to the maximum possible extent in all areas of disability —

physical, mental, social, vocational and economic.

2. The Workers' Compensation and Rehabilitation Board recognizes that while re–employment is the primary goal of workers injured at the workplace, this cannot be the only goal, and that Workers' Compensation and Rehabilitation Board must be concerned with independence and stability of the injured worker in all areas of life.

3. The primary objective of the Workers' Compensation and Rehabilitation Board rehabilitation services is to help an injured worker identify specific employment barriers and to explore options to their removal, taking into account the realities of both the injured worker's areas of strength and limitation, and the demands of the current, competitive employment market.

To this end, counselling and assistance in personal adjustment, in appropriate and realistic settings, must be offered, as well as comprehensive vocational evaluation and assessment, training in competitive work habits, skill training, training in job seeking skills and assistance in appropriate job placement.

4. The Workers' Compensation and Rehabilitation Board recognizes that the primary purpose of its rehabilitation division is to provide effective services by purchasing community and private services where appropriate, to achieve the goal of maximum independence in all five areas of rehabilitation.

5. The Workers' Compensation and Rehabilitation Board, through its Rehabilitation Division, is committed to working actively with injured workers, employers in the private and public sectors, organized labour and the community towards the integration into the employment market of injured workers with physical, emotional or social barriers.

6. The Workers' Compensation and Rehabilitation Board, through its Rehabilitation Division, is committed to including the injured worker as an equal partner in formulating rehabilitation goals, identifying programs and developing services.

7. The Workers' Compensation and Rehabilitation Board is committed to assure that adequate rehabilitation facilities are available, run by the community for the injured workers in the province.

## *Structure*

At the WCB today, claims, not rehabilitation, provides the point of focus. The power to grant or stop benefits is invested in the same counsellor who offers rehabilitation. This double–edged sword is quite often used as a weapon against the injured worker as the counsellor threatens to cut off benefits if the worker is in any way unco–operative.

As one WCB employee stated:

> *We have realized that our capacity to provide treatment and rehabilitation services is hamstrung by the perception of patients that we control benefits... (one) cannot combine treatment with adjudication...we have been claims–oriented rather than treatment–oriented and we don't like it.*

The structure of the WCB must be changed to separate the functions of claims and rehabilitation and rehabilitation must be made a full partner in the process. (See Appendix F which provides a guide to the flowchart for the proposed system.)

According to a staff member at COMSOC:

> *The only way to eliminate the punitive nature of the system is to separate rehabilitation from benefits... if the issue is to get them [clients] off benefits to save money, that will skew the rehabilitation process.*

As was pointed out earlier, of the 142 sections of the *Workers' Compensation Act*, rehabilitation is relegated to a vague statement of intent in Section 54. The Act was written mainly as an insurance scheme designed to financially compensate workers injured on the job and as such, may have served a good purpose.

The terms of reference of the Task Force did not include compensation aspects of the Act and its service delivery by the board. However, although the Task Force took pains to restrict its information gathering to the rehabilitation aspects, the overwhelming evidence (as can be seen by examination of the data assembled from the submissions as well as by the research) was that a great deal of the dissatisfaction by all parties centred on the unfairness of the financial aspects of the service delivery.

WCB staff seem to be generally negative toward injured workers who are not compliant and somehow blame them for their accidents. This leads to subtle and unconscious attempts to deny or reduce financial compensation. Again and again the Task Force heard the term "malingerer" used to describe injured workers who were fighting to get financial compensation while not displaying an overt eagerness to return to work. This stigma was used freely and without evidence, clearly as prejudicial a term as those used to demean and isolate members of other minority groups.

Yet it is the board's duty to communicate an understanding, empathetic approach to people who may have encountered so many barriers to re-employment that they have given up looking for work and are now fighting for financial independence.

* * *

> *The Panel believes that the failure to appreciate that a significant proportion of persons suffering from enigmatic chronic pain or pain magnification will in fact be victims of the failure or limitations of medical science rather than of their own psychological processes, has had a significant impact on the objectivity with which the compensation system approaches such cases. The Panel, therefore, examines the evidence as to the probabilities that such cases are cases of undiscovered organic pathology.*
>
> Workers' Compensation Appeals Tribunal,
> Decision No. 915
> May, 1987

* * *

The *Workers' Compensation Act* has failed to deal with the non-vocational aspects of rehabilitation and the reduction of suffering caused by accidents or diseases at the workplace. This disinterest is shown by the relegation of rehabilitation to a minor position within the Act, and in the failure to give it a prominent place in the governing structure of the board so that it would have a major impact on policy and decision making.

## *Some Important Changes*

Clearly, if rehabilitation is to be an important part of the board's activities the board's mandate will have to be changed, and that must begin with alterations in the Act itself.

* * *

> *Very little, if anything, is done to assist an injured worker through the* social, economic *and* mental change, *which is needed before he can successfully enter the job market... the board has allowed the original intent of rehabilitation to deteriorate.*
>
> United Steelworkers of America, Local 1005
> Hamilton, December 3, 1986

* * *

Therefore, to establish the importance of rehabilitation in the Act the Task Force recommends:

1. That the name of the Act be changed from *Workers' Compensation Act* to *Workers' Compensation and Rehabilitation Act* to reflect the importance of the rehabilitation function of the board.
2. That the name of the Board be changed to *Workers' Compensation and Rehabilitation Board.*

The next level of change that must be made, if the board is to respond to the needs of injured workers, is to have their interests represented on the board.

The Task Force therefore recommends:

3. That the Minister of Labour add one injured worker and a vocational rehabilitation practitioner to the corporate board of the Workers' Compensation and Rehabilitation Board.

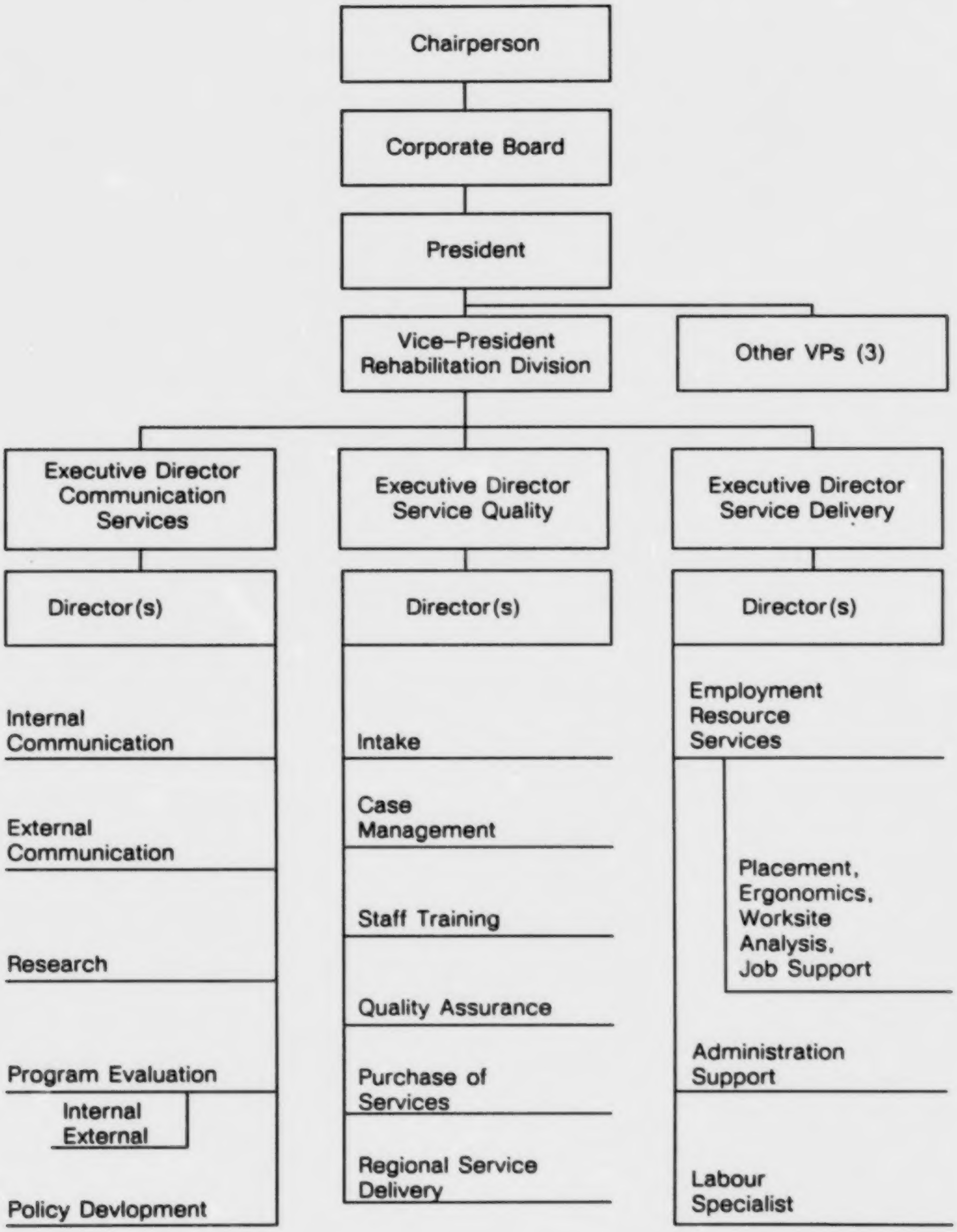
Within the Workers' Compensation and Rehabilitation Board, rehabilitation must not only be recognized in the title and on the corporate board, but also in the organizational structure. At present there are three vice–presidents, one of whom heads the service delivery function, including both compensation and rehabilitation. If rehabilitation is to increase in importance, it should also be represented at the vice–presidency level.

Therefore the Task Force recommends:

4. That four divisions be established, each headed by a vice–president.
    a) Policies & Special Services Division
    b) Strategic Planning & Analysis Division
    c) Compensation Services Division
    d) Rehabilitation Services Division.
5. That the management function of the VP Rehabilitation Services shall be the organization and service delivery of all rehabilitation services of the board. The organizational structure of the division shall include three executive directors whose functions are outlined in the appended chart. The titles of these directors should be *Director of Service Quality, Director of Service Delivery* and *Director of Rehabilitation Communications.*

The proposed organization chart that would deliver rehabilitation services is presented on the following page.

## Proposed Organization Chart


Chairperson
Corporate Board
President
Vice–President Rehabilitation Division
Other VPs (3)
Executive Director Communication Services
Executive Director Service Quality
Executive Director Service Delivery
Director(s)
Director(s)
Director(s)
Internal Communication
External Communication
Research
Program Evaluation
Internal
External
Policy Devlopment
Intake
Case Management
Staff Training
Quality Assurance
Purchase of Services
Regional Service Delivery
Employment Resource Services
Placement, Ergonomics, Worksite Analysis, Job Support
Administration Support
Labour Specialist

## Chapter 5

# The Right to Total Rehabilitation

- *present approach inadequate*
- *dignity and quality of life important*
- *hidden caseload (retroactivity)*

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*When I got admitted to Downsview Hospital, the first week I was there, I was given Dr. Harrison as a general practitioner...I didn't have half a sentence out to explain my problem and he says, "I think you read too many Reader's Digests and you're just like an old lady."...Well, I just backed off and I didn't say too much after that, you know. So, later on at Downsview, in the middle of everything, he said I would be taken off therapy because it was too costly, too expensive, it was a waste of money.*

Cyrille Beaulieu
Injured Worker
Elliott Lake, October 22, 1986

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*COCA honestly believes we are at a point where the vocational rehabilitation system should be totally re-examined and overhauled, such that it will take responsibility to insure that an injured worker recovers and is back on the job as soon as possible. The price of inaction in this account is high. We will simply witness the demise of the Workers' Compensation system as we know it.*

Mr. Tony Patullo
Secretary, Avenue Construction,
Chairman, Vocational Rehabilitation Committee,
Council of Ontario Construction Associations
Toronto, December 9, 1986

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The concept of rehabilitation has evolved greatly over the past years with the recognition that the impact of a disability is far more than the reduction of physical function. International organizations concerned with rehabilitation have shifted emphasis from impairments of function, or disability, to the reduction of the effects of the resulting handicap.

As far back as 1942, the National Council on Rehabilitation in the U.S. recognized that there are five essential elements to the rehabilitation process — physical, mental, social, vocational and economic. Following this principle and that of the World Health Organization and the International Labour Organization, the Task Force stated the goal of rehabilitation was:

> *to assist workers who have suffered occupational injuries or debilitating diseases linked to the workplace in the process of restoration, to the fullest physical, mental, social, vocational and economic usefulness to the maximum possible extent.*

This parallels the submission by the Ontario Federation of Labour, which stated:

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*That the Rehabilitation Division adopt a "whole person" concept in providing rehabilitation services, that involve the injured worker in planning an individual program that addresses his or her physical, medical, vocational, social, psychological and financial needs.*

Ontario Federation of Labour
Mississauga, December 12, 1986

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To clarify the meanings of the terms used to describe the five aspects of rehabilitation, the Task Force adopts these definitions.

**Physical Rehabilitation:** To remove or reduce the effects of the impairment to the maximum extent.

**Mental and Social Rehabilitation:** To reduce to the maximum extent possible, the emotional impact of the injury or disease and the handicaps and barriers that may arise and to restore dignity and emotional and social equilibrium.

**Vocational Rehabilitation:** To return the injured worker to employment where possible. Alternatively the goal then becomes one of the closest approximation to the former employment or other mutually agreed upon employment.

**Economic Rehabilitation:** To maintain the economic status of the injured worker, indexed to inflation from the pre-injury level.

## *Present Approach Inadequate*

The definition of rehabilitation is not unique with the Task Force. Again and again submissions to the Task Force stressed that the effects of an injury are far more than the physical disability.

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> *Lengthy periods of disability often result in serious financial difficulties (due to inadequate compensation — particularly those persons affected by ceilings), and severe alterations in lifestyle which impact on social and family situations. The experience of disability itself is generally a trauma affecting the worker and his entire family. Family problems, isolation from the workforce and work place associations have a negative effect on self confidence and self esteem.*
>
> C.U.P.E., Local 1750,
> Scarborough, December 8, 1986

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The WCB was repeatedly criticized for offering only vocational rehabilitation.

> *There are three dimensions to rehabilitation: medical, social and vocational. The Board focuses on vocational rehabilitation, which includes medical action and counselling.*
>
> OPSEU,
> Mississauga, December 12, 1986

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An important concern of the Task Force has been that rehabilitation services (in its narrow emphasis on medical and vocational), have been offered to injured workers only at the discretion of the WCB. The decision is made by claims adjudicators and frequently under pressure from medical personnel, WCB administration, lawyers of the injured workers and others with political influence. The way service delivery is determined is not only demoralizing to those who must make the decisions but destructive to those who receive them. Sweden, Australia and the Netherlands are among the constituencies that define rehabilitation holistically.

The Task Force therefore recommends:

13. That any worker who sustains a serious injury or a debilitating disease linked to the workplace shall have the statutory right to all rehabilitation required by that worker. Rehabilitation shall be defined as "to assist workers who have suffered occupational injuries or debilitating diseases linked to the workplace in the process of restoration, to their fullest physical, mental, social, vocational and economic independence to the maximum possible extent." Serious shall be defined as a situation in which the worker is unable to return to the job within 30 days of injury.

The board shall therefore do what is deemed necessary or expedient in full partnership with the injured worker.

This parallels Section 146 of the Quebec Act, which reads:

> *To ensure the worker's right to rehabilitation, the Commission shall prepare and implement, with the worker's collaboration, a personal rehabilitation program, which may include according to the worker's needs, a physical (medical), social (psychosocial) and professional (vocational) rehabilitation program.*

## Dignity and Quality of Life Important

While the Task Force recognizes that re-employment is the ultimate goal of the rehabilitation process, it is equally aware vocational rehabilitation may not be appropriate for everyone. When desired, the injured worker must have the right to receive such services, but this should not be offered at the expense of other forms of rehabilitation. Nor should those, for whom re-employment may be impossible, be relegated to the discard bin.

The Task Force feels strongly that in all areas of the individual's life where such needs exist, rehabilitation services should be offered. The quality of life of an injured worker, his or her status within the family and within society, the individual's self-worth, dignity and independence must all be preserved.

The Task Force recognizes that while the work ethic is predominant in our society today, over 6% of able-bodied adults in Ontario cannot find meaningful work and there is a much larger group who have given up the struggle to find a job. These people must not be seen as pariahs. Rather they deserve the right to a decent quality of life. This is especially true of those who have incurred a disability at work. The right to rehabilitation must be inscribed in the Act and acknowledged with empathy and understanding in the service delivery system.

## Hidden Caseload (Retroactivity)

The Task Force is concerned that there are a number of workers who were denied or never received rehabilitation services and have not recovered to the point of being able to return to work. There is no way to identify the extent of this hidden caseload, but it was estimated to be about 12,000 to 18,000 each year. In the hearings held across the province, a number of injured workers identified themselves and complained about the WCB's lack of regard for their needs.

Hidden caseload was defined as:

> *Those injured workers who could benefit from the receipt of the full range of rehabilitation services but have not received them either because they were not referred or because they were denied the services.*

Many workers have also received inadequate services, especially in light of the extended, holistic definition of rehabilitation. Many are underemployed and poor. The reopening of many of these cases is incurring considerable expense to the WCB and frustration and anxiety in the injured workers. The Task Force feels strongly that a case review should be carried out by the Workers' Compensation and Rehabilitation Board and should offer a full range of rehabilitation services to those who have been inadequately served the first time.

The Task Force therefore recommends:

14. That the board take a pro–active role in identifying those injured workers who have not received, have been denied, or were never referred to rehabilitation services and that the board accept the responsibility of supplying satisfactory rehabilitation services and ensuring financial security.
15. That all cases in WCB which have been open more than 30 days but not referred to Vocational Rehabilitation Services be referred for service under the broader definition of rehabilitation.
16. That the board take a pro–active role in identifying those injured workers who have received vocational rehabilitation services but are dissatisfied with the rehabilitation services received and that the board accept the responsibility of supplying satisfactory rehabilitation services and ensuring financial security.

## Chapter 6

# Mandatory Reinstatement

- *some statistics*
- *re–employment help from accident employer*
- *role of organized labour*

* * *

> *I have worked for General Motors for 26 years, and after my first accident, I was told they don't take back [the] handicapped, and I've been fighting ever since...*
>
> Mr. Richard Hack
> Injured Worker
> Oshawa, December 1, 1986

* * *

> *The enabling section of the* Workers' Compensation Act, *Section 54, is entirely discretionary. It does not* **obligate** *either the Workers' Compensation Board or the accident employer to take any action. In content, it appears to be no more than a token gesture paying lip service to the idea of Board involvement "in getting injured workers back to work". This section has no teeth.*
>
> Niagara North Community
> Legal Assistance
> St. Catharines, December 2, 1986

* * *

At first glance, one would accept without hesitation the principle that a worker injured at the workplace, has the right to reinstatement to his or her former job. Yet this seemingly fundamental principle is not held by law. Reinstatement is not mandatory, but exists only at the discretion of the employer.

* * *

> *With respect to the rehiring of injured workers, we are supportive of the right of an injured worker to be reinstated, if able, to his/her former job. We are supportive of that. In fact, more than that, we practice it.*
>
> Mr. Albert Magee,
> Director of Human Resources, INCO
> Sudbury, October 24, 1986

* * *

## Some Statistics

When the outcome is clear, the injury is visible and return to the worker's former job is straightforward and needs little energy or money, reinstatement tends to offer few problems. In 1985, 48.5% of the total claims made to the WCB were no lost-time claims. The injured worker returned to his or her previous job without the need of rehabilitation services. However in 1985, of the total number (5,945) reported rehabilitated by the Vocational Rehabilitation Division, only 36% were returned to the accident employer either to the same job or a modified one with the same employer. In that same period of time, 46% were reported placed with a new company.

* * *

> *For years the mining industry in Ontario has actively pursued programs to ensure that injured employees are reinstated to meaningful employment. In preparing for this presentation we collected, for perhaps the first time, our data in terms of how involved we have been with rehabilitation and reinstatement. We were both pleasantly surprised and encouraged by what we found.*
>
> The Ontario Mining Association
> Thunder Bay, October 20, 1986

* * *

The Task Force investigated existing rules and regulations regarding re-employment of injured workers in other countries. For example, France and Germany have widely different systems, regulations and applications of legislation, a host of historical determinants of present situations, and many seemingly arbitrary differences between the jurisdictions. However, both find it difficult to get handicapped workers back to work. The large and well-financed bureaucratic institutions of France and West Germany are doing a poor job of reintegrating them into the work force. Sometimes, as in France, they actually work against such reintegration, quite possibly as a matter of policy.

In fact, Quebec is the only jurisdiction in Canada with re-employment legislation. It goes beyond mere bureaucratic action to prevent victims of work-related accidents and illnesses from joining the unemployed, or as in France, the wrongly and under-employed.

## *Re-Employment Help from Accident Employer*

In interviews with a randomly selected sample of 120 injured workers who had received vocational rehabilitation services, few reported getting re-employment help from their preinjury employer. Moreover, only 34 of the 120 workers indicated that they were "very satisfied" or "somewhat satisfied" with the help they received from the previous company.

**INJURED WORKERS' INTERVIEWS RE-EMPLOYMENT HELP FROM ACCIDENT EMPLOYER**

| | Frequency | Percent |
|---|---|---|
| Offered old job | 9 | 8.0 |
| Offered different job | 12 | 10.6 |
| Modified old job | 6 | 5.3 |
| Offered severance | 3 | 2.7 |
| Offered lesser job | 4 | 3.5 |
| Didn't help at all | 40 | 35.4 |
| Offered job couldn't do | 20 | 17.7 |
| No jobs available | 19 | 16.8 |
| (Missing) | 7 | |
| | 120 | 100.0% |

The failure to return the injured worker to the pre-injury job must surely be expensive for the WCB and the employer. But the costs to the injured worker are far greater than only financial loss — failure to return to pre-injury employment may result in years of frustrating job search, depression or even uprooting from the community.

The Task Force heard hundreds of presentations at its public hearings, and many of them focused on this very point. Workers who required rehabilitation services couldn't get back to their pre-injury jobs. The research indicated that 35% of the interviewed workers stated their former employers didn't help at all; 18% said they had been offered alternate jobs they couldn't do. Only one in four of the injured workers were offered their old position back, a different one, or modified work.

Therefore the Task Force supports the worker's right to reinstatement and recommends:

17. That a worker who is injured at the workplace or contracts an occupational disease shall have the statutory right to return to the pre-injury job. Where the worker is no longer capable of performing that job he or she shall have the right to another job in the same enterprise, respecting seniority rights.
18. That where the company no longer exists, the injured worker shall be assisted by the Rehabilitation Division of Workers' Compensation and Rehabilitation Board to find alternate employment.
19. That the Minister of Labour ensure that Section 9 of the Ontario Human Rights Code, 1981 is incorporated in the *WCRB Act*.

## *Role of Organized Labour*

For the approximately 30% of Ontario workplaces that are organized, some unions play a role and many more could in facilitating the re-employment of injured workers, primarily through the mechanism of the collective agreement, but also through informal mechanisms and through health and safety committees.

### The Collective Agreement

In examining the role of contract language in providing protection for injured workers, it is important to recognize that language is the result of negotiations and embodies, as a consequence, a set of compromises.

It is in the interest of management to retain discretionary power over hiring, promotion, retention and lay-off. It is in the interest of the union to minimize arbitrary authority and to establish procedures that are understood to be fair.

Seniority has come to be accepted as the fairest mechanism; length of service confers a variety of job rights and is acquired uniformly. As a consequence, seniority principles are at the heart of most collective agreements.

This section outlines some of the existing contract provisions for returning injured workers to the workplace. A variety of agreements employ similar mechanisms; those selected as illustrations represent a type. The empirical data on the effectiveness of this language are not available. While it would also be useful to know the proportion of establishments which are covered by different types of language, these data are not available either.

## Every Effort

The most general language in agreements provides that the company will make efforts to return injured workers to suitable employment.

A sample of existing clause:

> *In the event of employees sustaining injuries or becoming affected by diseases during the course of their employment ... and becom[ing] physically handicapped as a result thereof, every effort will be made by the Company to give the handicapped employee such suitable employment as is available.*

## Waiver of Posting Requirements

In these instances, language facilitating the return of injured workers creates a mechanism whereby vacancies in bargaining unit jobs are filled by injured workers without posting to the rest of the bargaining unit. The ease with which this can be accomplished depends on, among other factors, the availability of work and on the range of work available within the bargaining unit.

In bargaining units that include a narrow range of jobs, there may not be alternative work that is suitable or that, at least in principle, can be accommodated to a particular injury. However, where suitable work is available, waiving posting can make work available to employees with less seniority since it specifically precludes movement on the basis of seniority alone.

A sample of existing clause:

> **Disabled Employees** *The parties may waive the provisions of Articles [recall] and [posting requirements] by mutual agreement of the joint Union–Management Committee in order to place a disabled employee into a vacancy when he is unable to perform his regular job because of a permanent physical disability or medical condition.*

## Bumping Rights

Another mechanism for return to work is the specific provision of bumping rights for injured workers. The language provides that re–entry can be made into an occupied job if the injured worker has greater seniority than a worker in the existing suitable job. In some instances, while seniority is both department–specific and plant–wide, provision is made for seniority to be carried between departments in order to accommodate an injured worker.

A sample of existing clause:

> *If an employee, as a result of an occupational injury or illness, becomes physically handicapped to the extent that he is unable to perform "their" regular work, and providing proof in the form of writing from the WCB, the employee may invoke his Divisional seniority to obtain a job which he is able to perform when his seniority is greater than that of the employee occupying the job in his Division. The employee being displaced must be the most junior [person] in the Division on a job the senior person can satisfactorily perform. Selection of the job will be made by Divisional supervision after discussion between the parties with the approval of the Company physician. The period of physical incapacity must be estimated by the Board to be in excess of six months before the terms of this clause may be applicable. Where these terms do not apply the Company will endeavour to give the employee such suitable employment as is available.*

## Designated Light Duty Jobs

This type of provision usually involves the development of a list of jobs which are designated light duty and which can only be filled by anyone other than an injured worker if there are no injured workers requiring a job. In some instances, these jobs are only available on a temporary basis to workers who are judged to be able to return to their regular job within six months; while in other cases they are designated for those whose condition will not permit a return within six months. Some provisions contain both clauses with priority given to employees with long-term disabilities.

A sample of existing clause:

> *Jobs for incapacitated employees [eight job classes listed]. Employees assigned to the above jobs shall be those whom the parties hereto mutually agree upon or are designated by the WCB or determined by the plant doctor as being incapacitated by reason of injury, illness, age or mental health and are therefore unable to perform regular duties.*
>
> *Employees who suffer a compensable injury and who may be required to do light duties or who are unable to perform their regular work temporarily because of such injury, will not be eligible for the jobs in question if an incapacitated employee as defined above requires such job.*

In addition to formal contract language pertaining specifically to the return of injured workers, collective agreements may provide further support for injured workers, in language extending minimum standards set by legislation. For example, regulations governing pensions, plant closures and health and safety have all been extended through collective bargaining to cover the needs of injured workers.

## Informal Mechanisms

Outside the collective agreement, unions may still actively promote the return of injured workers through informal mechanisms. Some degree of job protection for injured workers has been provided through union/management informal agreements. Particularly where they are long-standing, these practices have been upheld at the Ontario Labour Board. In one case, an able-bodied male appeared before the Ontario Labour Relations Board to challenge an informal union-management agreement to place injured workers in "light duty" jobs upon their return to work. The practice was long-standing, and successful, and was reaffirmed by the membership and leadership of the Union in the course of deciding not to pursue this worker's grievance.

Vice-Chair MacDowell, writing for the OLRB, argued:

> *It is [a] perfectly reasonable effort by the union and the employer to recognize and accommodate the need of these disadvantaged employees ... while there may be no strict entitlement to these rights under the agreement, this is not the sort of "invidious discrimination" that the Act prohibits.*

## Obstacles to Bargaining Units

However, bargaining units may not be able to bridge two barriers that impede the return of injured workers in several industries. The first is the problem of finding "suitable" work in establishments where bargaining units are stratified by occupation. The second is the issue of job modification.

## The Problem of Finding "Suitable Work"

This problem arises primarily in the public sector; in hospitals, school boards, municipalities and colleges, where the bargaining units may number from three or four to up to twenty. These will frequently include building trades and/or skilled trades bargaining units as well as units of inside and outside workers, and different units within each of these. In the private sector, the basic division is often between plant and office. Within plant and between plant and maintenance, there may also be a number of distinctions. The result is some degree of purity of job type or occupation.

In an establishment with multiple bargaining units, finding re-employment for an injured worker frequently entails identifying a suitable job outside the bargaining unit. Collective agreements do not deal with work outside the unit. Unless some form of joint committee structure is developed, the chances of finding suitable work for injured workers may be small in many units.

There is understandable reluctance to enter into such forms of joint committees, but that may be the only route whereby an employer becomes obligated to consider all work available within the establishment in designating alternate work. Arbitrators have been unwilling to obligate employers to look outside the units.

A good illustration of this difficulty arises in the case of nurses who have high rates of back injury. Light-duty work for nurses is difficult to find within the bargaining unit, because they must be physically prepared to assist patients when required.

When the union argued that an injured nurse was entitled to re-employment, and that the only "suitable work" was in management, Arbitrator Devlin concluded:

> *given the limitations on the Association's jurisdiction and authority to bargain on behalf of the part-time nurses, we must conclude that in the absence of clear language, contrary to the rights and obligations as set out in [the] article, were intended by the parties to cover those positions and work over which the Association had the duty to bargain, that is, work within the bargaining unit.*

## The Issues of Job Modification

The second problem, that is obtaining modified work for injured workers, cannot be addressed in collective agreements when control over the work force process and the design of jobs is almost uniformly an exclusive management right. Finding "suitable" work for an injured worker by reorganizing a job is a relatively unconstrained prerogative of management in most industries.

Finding modified work is even more difficult for jobs in which high rates of injury are identified. Certainly, the primary responsibility for modifying jobs and increasing the safety of large numbers of jobs and of the worksite resides with management.

Relying on collective agreements as the vehicle to protect the rights of injured workers places an undue burden on the union to negotiate those rights. A more appropriate vehicle would be a legislative and policy framework that clarifies worker rights and management responsibilities in this area. From this base, unions could negotiate rights and implementation through collective bargaining.

## Chapter 7

# Case Management

- *what is case management?*
- *case management skills*
- *rehabilitation services providers*
- *present role of rehabilitation counsellors*
- *qualifications of counsellors*
- *caseload size*
- *employment specialists*

* * *

> *I went to my family physician. My family physician said, "We have to get you out of that program. You are getting into trouble, but I cannot pull you from that program until you get in touch with your counsellor..." I continued to go to the program and I started to call the counsellor. Each day I am getting worse and worse. My counsellor is either out of town, my counsellor will get back to me.*
>
> Ms. Maureen Clark
> Injured Worker
> London, November 4, 1976

* * *

> *...the major concern with us is again case management, which is provided by the WCB rehabilitation specialist in Toronto. Now this person we find is not easily accessible, often not in the office, and when called, no one else is assigned to do the case management...the follow-up is usually one visit per month and if we're doing the assessment that may [take] four weeks to six weeks, one visit really isn't sufficient to provide a good program.*
>
> Ms. Joan Teresianski
> Program Manager, March of Dimes
> Sault Ste. Marie, October 21, 1986

* * *

One of the most common complaints heard by the Task Force in its travels across the province was that injured workers could not identify a specific individual with whom to discuss problems and develop a working relationship. File shuffling was common, and no single person seemed to carry responsibility for an injured worker. Clearly this is not a therapeutic situation. Rather, it illustrates that the board's main concern is, ultimately, paper efficiency.

Another complaint heard repeatedly was that there seem to be multiple copies of each file, each copy dealing with different aspects of a client's services, and that these files are not identical. Thus a client may receive two letters from different members of the board's staff with different instructions or pronouncements. In fact, in one case recorded by the research team, two letters were mailed from the same staff member, with the same date, to the same client, each with different instructions. The confusion can only lead to uncertainty, anger and frustration.

The failure to communicate in a clear and direct manner reduces the quality of the service and increases its cost. The solution can only lie in the establishment of an effective case management system.

Over 20 years ago, Sussman (1966) stated that:

> *the disabled client may be caught in the intricate maze of the interagency referral system and the successful matching of his/her disability condition and rehabilitation potential and subsequent treatment is more a function of fortuitous circumstances than of rational planning.*

The range of treatments offered in rehabilitation is great and a listing of them would be difficult. They range from the application of physical rehabilitation in all its varied alternatives to retraining, relocation or workplace modification. They include such things as family counselling, aptitude testing, removal of all barriers and learning methods of anxiety control. Any one or a combination of these programs might be appropriate for the rehabilitation of a disabled worker.

* * *

> *Rehabilitation Counsellors have become actively aware that they are not merely providing Vocational Counselling but also family, financial, personal and social counselling. Because of the severe effects of the recession, Rehabilitation Counsellors are noticing that more severe and complex problems are being experienced by the injured workers they counsel. The financial and vocational aspects to a worker's particular problems cannot be separated and treated separately.*
>
> CUPE, Local 1750
> Toronto, June 3, 1983

* * *

At the WCB today, the selection of appropriate programs is conducted in a haphazard manner resulting in a lack of comprehensiveness. Files of clients are shunted from desk to desk with one counsellor making a decision on a particular program with little or no regard for what the previous one may have done. Frequently decisions are made without even seeing or consulting with the client, who is informed only after they are made.

## What is Case Management?

Some agencies have adopted the case management model of service delivery that assigns a case to a single individual, called a **case manager**, who bears responsibility for the outcome.

Case management has been defined in many ways. But probably the most appropriate one is the definition of Kemp (1981), as:

> *a method of providing comprehensive, unified, coordinated, and timely services to people in need of them through the efforts of a primary agent, who, together with the client, takes responsibility for providing or procuring the services needed.*

The process of case management has been defined by Kemp as follows

- There is individualized assessment of an injured worker's situation, needs and goals based on an understanding by the case manager of what the worker is able to achieve.
- The case manager identifies the services needed to satisfy those needs.
- The case manager identifies barriers preventing delivery of services.
- Provision or procurement of the services determined to be necessary is provided.
- The case manager monitors and follows up the services to insure that they have actually been delivered and to determine their effectiveness.
- The case manager monitors and follows up the injured worker's file to insure that no further services are required.

Two characteristics of the case management role that need to be stressed are *comprehensiveness* and *continuity* of service provision. The case manager must make certain that every appropriate rehabilitation service is offered and in a timely fashion. Furthermore, whatever the outcome of the process, the client must be satisfied with the services rendered. The latter is, of course, assumed since the injured worker is a partner in the decision–making process at every step of the delivery system.

Continuity means that the client is not neglected, his or her file not lost in a maze of procedures or among other files, and that the services are delivered at the appropriate time. The client is seen as early as possible after the accident, and the case manager has continuing responsibility for the client's rehabilitation.

## Case Management Skills

Clearly this job calls for a superhuman person, one who can fulfil an enormous array of functions. Cassell and Mulkey (1985) have described the case manager as one who possesses four sets of skills: technical, human, conceptual and implementation.

Technical skills, for example, include methods and techniques for counselling and for processing cases through an organized system towards the goals of the client.

Human skills are established, sequenced, interpersonal relations patterns that are necessary to help clients reach their objectives.

Conceptual skills are seen by Cassell and Mulkey to be established, sequenced, mental patterns letting one understand the total working of an organization or a process. It is the ability, for example, to visualize how individual goals and objectives fit into the bigger picture. It is the skill to quickly select the significant indicators both for success with clients and the problems that are likely to occur.

Implementation skills are required for effective management. Where conceptual skills provide a perceptual base or establish proper functional boundaries; where technical skills provide a foundation for action by acquiring specialized ways of responding; and where human skills assist in establishing a medium for those two skills to occur or interact; implementation skills provide those mechanisms for action. They involve such elements as personal motivation, personal energy level, commitment, acting on priority systems established and the attitude of the counsellor.

Clearly then, case management is a process in which an individual uses a set of skills and roles to ensure that an injured worker receives the services that are needed to achieve maximum rehabilitation in a co-ordinated, effective and efficient manner.

❑❑❑

> *Case Management includes timely contact with workers and other involved parties, and also with record keeping. The most effective method of contact is that which is based on the needs of each individual on the caseload, as opposed to a more mechanical approach where everyone is seen every three or four weeks, regardless of their circumstances. Some workers need more time spent with them (perhaps at the beginning) while others do not.*
>
> CUPE Local 1750
> Toronto, June 3, 1983

❑❑❑

The Task Force therefore has accepted the principle that a system of case management should be established where a trained rehabilitation counsellor will work closely with each injured worker to plan his or her rehabilitation program. The Task Force recommends:

40. That each file of an injured worker that comes to rehabilitation services shall become the responsibility of a single staff worker, called the case manager, who shall receive the file from the intake counsellor and be responsible for choice and delivery of appropriate service until one year after the file is closed.
41. That the case manager shall be responsible for appropriateness, comprehensiveness and continuity of the service provision.
42. That the functions of the case manager shall include the following:
    - to assess the injured worker's needs
    - to develop a therapeutic relationship with the injured worker
    - to plan and organize all rehabilitation services
    - to procure and expedite services
    - to keep records of services given and costs incurred
    - to advocate for and represent the client
    - to organize and manage the entire caseload
43. That the process of rehabilitation service delivery followed by the case manager shall be as illustrated in the flow chart, (see next page).
44. That the case manager involve the injured worker as a partner in all rehabilitation decisions so that the injured worker shall be a participant in all phases of service selection.
45. That the training of the case manager shall be that of the rehabilitation counsellor at a level that would give her or him recognition as a senior member of the rehabilitation team.

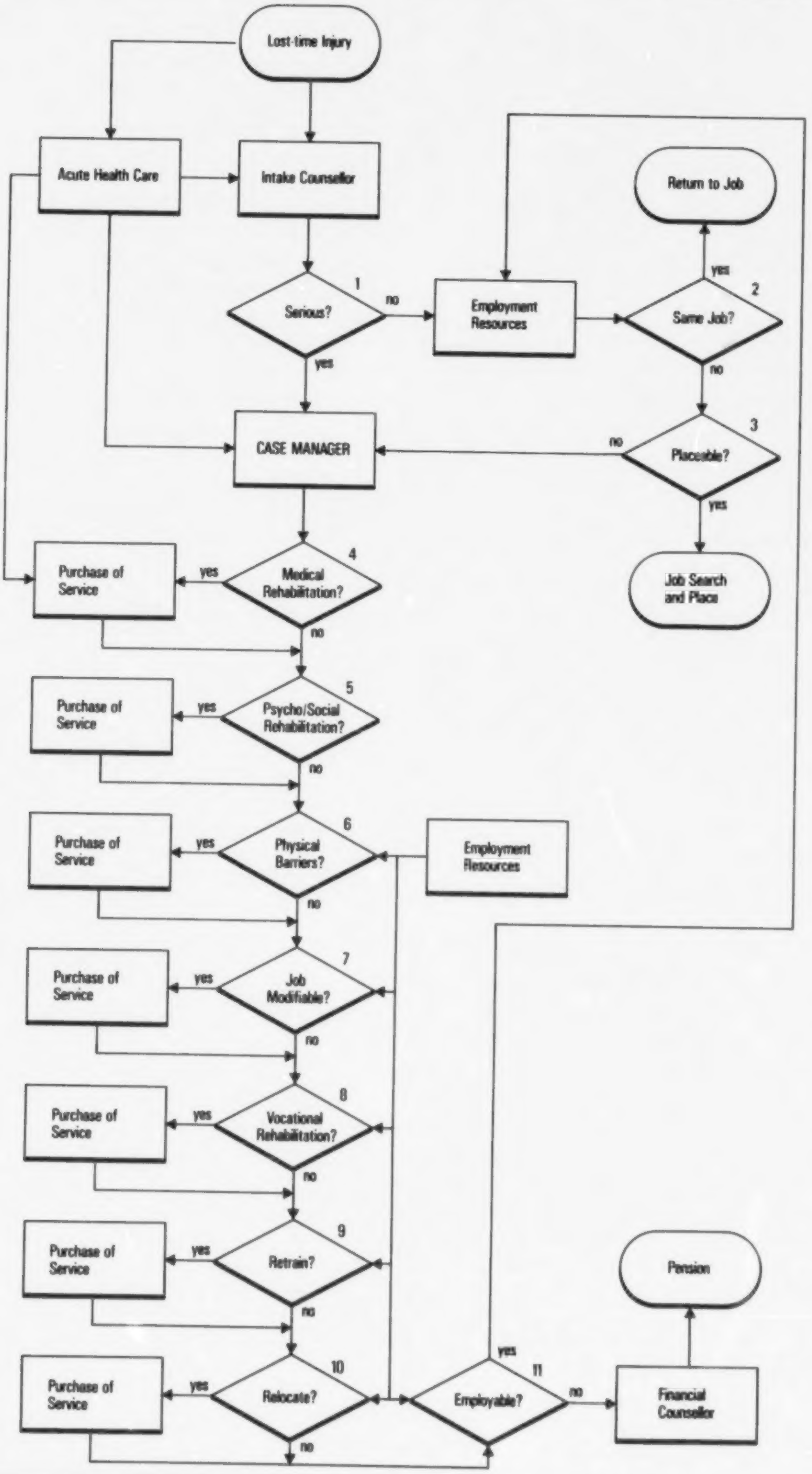
## *Rehabilitation Services Providers*

Vocational rehabilitation services are delivered by the WCB through a staff of front line workers that vary in training, experience and job description. Staff can be shifted from one job classification to another with little regard to background, experience and training. No preparatory skills are needed for particular jobs and no specific bodies of knowledge are required to perform specific functions. Rather, there is a reliance on in-house training. But this training tends to focus mainly on administrative procedures that make file management easier.

Essentially, there are two bodies of knowledge and two sets of skills required to deliver comprehensive service in rehabilitation.

The first centres on the identification and removal of internal barriers that restrict employability. These can be physical, emotional or social. A person who has the knowledge and skills to identify and remove internal barriers must be trained to appreciate the invisible components of physical injuries.

# Proposed Rehabilitation System


Lost-time Injury
Acute Health Care
Intake Counsellor
1
Serious?
no
yes
Employment Resources
Same Job?
2
yes
Return to Job
no
3
Placeable?
no
yes
Job Search and Place
CASE MANAGER
4
Medical Rehabilitation?
yes
Purchase of Service
no
5
Psycho/Social Rehabilitation?
yes
Purchase of Service
no
6
Physical Barriers?
yes
Purchase of Service
no
Employment Resources
7
Job Modifiable?
yes
Purchase of Service
no
8
Vocational Rehabilitation?
yes
Purchase of Service
no
9
Retrain?
yes
Purchase of Service
no
10
Relocate?
yes
Purchase of Service
no
11
Employable?
yes
no
Financial Counsellor
Pension

The second body of knowledge and set of skills focuses on external barriers, those environmental constraints that militate against re–employment. Among these are work conditions in the community, demands of the workplace and the factors that contribute to job satisfaction.

These sets of skills cannot be isolated completely. It would be ludicrous to believe that one can be sensitive to the client's problems without being aware of the difficulties adjusting to a job and society at large. Nor can one confine one's knowledge to employment demands without an awareness of personal characteristics that contribute to employability.

The first set of skills is embodied in the role of the rehabilitation counsellor, trained academically to help people cope with personal problems. The second set is required by the employment specialist who gains experience in the workplace.

It is rare to find people who combine both of these skills, training and work experience, and the Board should be encouraged to search for such individuals and provide them with incentives to come to work for it. But since such persons are rare, it is clear that a team approach within rehabilitation services delivery is the alternative.

> *The specialist teams suggested need to be multidisciplinary in nature in recognition of the complexity of factors that go into injured worker rehabilitation and particularly so in the case of chronic back injured clients.*
>
> *Need of recognition of the highly specialized nature of the work with training to the level that the rehabilitation counsellor can take his/her place as an equal partner along with other rehabilitation specialties in the rehabilitation team.*

The composition of the rehabilitation teams must, of course, vary with their locations and availability of specialists. In a large urban centre a team could consist of a large number of people who would contribute their expertise when necessary. In small communities the available personnel may be more restricted and therefore the teams might have only a rehabilitation counsellor and an employment specialist. The former would normally serve as the case manager while the latter would plan and carry out rehabilitation programs related to work serving as the individual who represents the employment world.

In the long run, the quality of service delivered by a service organization rests firmly on what its front–line workers can deliver. The staff who help clients and communicate with the public on a daily basis can establish and maintain the reputation of an organization as well as save it unnecessary costs.

At the WCB today, this central role is performed mainly by a claims adjudicator who determines the appropriate compensation and refers the client to the Vocational Rehabilitation Division.

At the Workers' Compensation and Rehabilitation Board the role would be shared by the rehabilitation team members, who would monitor the injury closely, intervene early and design and conduct a rehabilitation program specifically suited to the injured worker.

## *Present Role of Rehabilitation Counsellors*

The Task Force conducted two studies to discover the attitudes and feelings of the present rehabilitation counsellors towards their jobs and the environments in which they work.

In one study, questionnaires were sent to all 193 rehabilitation services staff who work with injured workers and 119 responded (62%). One can only speculate why the remainder failed to cooperate even though a reminder was circulated to everyone. Information filtered back to the Task Force that some counsellors were fearful of being "psychologized", a surprising feeling since these counsellors use test results in their daily work and should not be fearful of their misuse.

Counsellors also seem to have been reminded strongly by someone that they did not need to respond, implying that they ought not to co–operate. This, too, is strange because they were informed that all responses were anonymous, and failure to respond meant only that they weren't included in the final tally.

In addition to the questionnaire, 50 staff members, randomly selected from across the province, were interviewed in private sessions lasting from two to three hours. During this time they were given the opportunity to express how they felt about their job and the conditions under which they worked.

Generally, they did not complain greatly about their jobs. Their feelings were that those dissatisfied with the WCB leave after a brief stay and go elsewhere. The ones that remain seem to have settled into the organization and developed a flexible manner of working. They accept that which can't be changed and work within the structure to deliver what they consider to be the best service.

Yet, in a questionnaire of satisfaction of social service delivery personnel at the workplace, WCB counsellors showed a significantly greater degree of dissatisfaction with almost every aspect of their work and work conditions than other professionals in the same field. This agrees with a 1983 CUPE study in which 70% of responses suggested that morale is either "low" or "very low". Clearly, counsellors who remain at the WCB put in their time (and even overtime) but are unhappy with their jobs.

There is great variability in the backgrounds, skill levels and degrees of satisfaction among the rehabilitation counsellors. Distinctions seem to be related to the length of service, location in Ontario, age, educational background and type of supervision. In sum, the picture that was obtained from the counsellors was very mixed. One can hardly describe an average because differences are so great.

Some come to the WCB because the pay is quite high for B.A. graduates. Many see employment at the Board as a job rather than a career and remain because of the money. Some, looking for a career, fail to find advancement and leave for other positions. Burnout, however, does not appear to be worse than for human service workers elsewhere.

Injured workers have complained about a patronizing attitude by the counsellors. One can only speculate that it reflects the attitudes of those who see themselves merely putting in time on the job and have little knowledge or empathy for injured workers. With the opportunity to upgrade themselves, only 10 of the 119 counsellors questioned stated they were enrolled in formal upgrading courses. While in–service courses and workshops are offered, these are not serious ways of upgrading since there is no measure of quality of learning and no incentive for good performance.

Counsellors feel that they have high input and flexibility in purchasing assessment and therapeutic services outside of WCB. Yet financial statements show that most services are purchased from psychologists for psychological and vocational testing. This is a disproportionate amount compared to that spent for retraining and relocation.

In Europe and North America there is little consistency in the selection of people who perform the role of rehabilitation counsellors. Where rehabilitation is restricted to vocational assessment and intervention, a counsellor's academic level is not as important as work experience. Where rehabilitation is holistic, the qualifications required of counsellors tend to include graduate training in the social sciences, psychology or social work, with an emphasis on how to serve people with disabilities.

In the U.S., the profession of rehabilitation counselling was established by an Act of Congress in 1954. Since then an educational and research base has been established and now rehabilitation counsellors are accredited on the basis of expertise demonstrated by schooling, supervised training, and experience in the field. They are also required to continue studying to maintain their accreditation.

In Ontario, as in the rest of Canada, rehabilitation counselling is conducted by people trained at various levels with different backgrounds. Some agencies will hire only counsellors with masters degrees while others, such as Workers' Compensation Board, tend to hire people with bachelor level training and less, without regard to whether they have been trained in counselling theory and practice.

The activities that rehabilitation counsellors perform depend mainly on the goals of the organization where they work. In vocationally oriented organizations, where counsellors concentrate on the assessment of employability and rehabilitation of work skills, academic level is considered to be of secondary importance. In the Vocational Rehabilitation Division of the Ministry of Community and Social Services, where the rehabilitation counsellor is responsible for total rehabilitation, he or she must have the knowledge and skills to identify and reduce the emotional impact of disablement as well as assess the client's needs in his or her handicap. So, the large majority of counsellors who act as case managers are social workers or have masters degrees in programs that teach counselling skills. Recently, M.Eds. with counselling skills and graduates with rehabilitation services certificates from the York–Seneca program have also been hired.

In the WCB today, the rehabilitation counsellor, for the most part, determines the client's vocational potential and strategies for re–employment, a function performed in the U.S. mainly by "employment counsellors". These individuals have varied backgrounds, often trained to the bachelor's level, but with extensive experience in industry, business or the skilled trades. The WCB counsellors however are not required to have either the counselling background or the industrial/business experience.

Yet the "Typical Duties" section of the WCB job description of Rehabilitation Counsellors 1 and 2 seems to be quite broad and includes a great deal more than vocational rehabilitation. According to the job description, the rehabilitation counsellor

> Provides vocational rehabilitation services to injured workers by:
>
> - counselling and advising injured workers on rehabilitation measures available, dealing with social and financial problems affecting return to work.
> - evaluating injured workers' vocational potential through the interpretation of medical, vocational and psychological information.
> - planning, developing and implementing appropriate rehabilitation programs in co–operation with the worker and prospective employers to accomplish effective job placement.
> - conducting investigations, preparing reports and making recommendations consistent with the policy of the Board and in the best interest of the worker's early rehabilitation.
> - providing Claims Adjudication with the information necessary for the determination of the extent of claims entitlement.
> - documenting all expenditures of Section 54 funds and requesting approval in accordance with established policy.
> - contacting other branches of the Board, Canada Employment and Immigration Commission, community agencies, doctors and other services involved with the worker's rehabilitation.
>
> Performs specific duties as assigned:
>
> - Counsel and provide guidance to injured workers in order to facilitate successful rehabilitation.
> - Contact employers, various community agencies and utilize internal resources such as H & RC, rehabilitation specialists, rehabilitation counselling staff, the Employment Services Section, and the Social Work Section in planning and implementing rehabilitation programs for injured workers.

However, rehabilitation counsellors reported their jobs consisted mainly of returning injured workers to employment and attempts to extend the sphere of service are frequently discouraged. Once again, the discrepancy between the printed philosophy and actual practice appears.

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*Since 1974 there has been a visible shift in emphasis from a service which provided counselling to the injured workers to one which concentrates on job matching/placement in order to service statistical requirements.*

CUPE, Local 1750
Toronto, December 8, 1986

❑ ❑ ❑

The Task Force, recognizing the injured worker needs far more than merely vocational rehabilitation, believes the principles of rehabilitation must be altered to reflect its holistic nature. The functions of rehabilitation counsellors must also change to reflect the case management role and the need for effectiveness in supplying total rehabilitation services to the injured worker.

Based on this position the Task Force recommends:

46. That rehabilitation counsellors with experience be recognized as case managers in the rehabilitation services delivery system.
47. That case managers shall have the authority to design individualized rehabilitation programs to fit the uniqueness of every injured worker.
48. That each case manager shall provide direct services to injured workers to the extent that his or her training, skills and abilities will allow.
49. That rehabilitation counsellors be encouraged to investigate and select services in the community not provided by Workers' Compensation and Rehabilitation Board, based on assessment of effectiveness and quality of service.
50. That all rehabilitation counsellors be required to continually visit and monitor employment conditions in the workplace.
51. That all rehabilitation counsellors be required to present the Workers' Compensation and Rehabilitation Board and its services to employers, workers, professional groups and the public at large by maintaining positive two-way communications.

## Qualifications of Counsellors

While most of the rehabilitation counsellors at the WCB are trained academically at least to a bachelor's level, the training rarely includes courses in understanding the behaviour of those who have suffered traumatic events, in counselling techniques, or in methods of serving people with physical disabilities. Counsellors who have been at the WCB longer usually have less education, suggesting that the Board has started to hire better academically trained staff.

**Training of Vocational Rehabilitation Staff**

| | Academic Education | Avg. Years at WCB |
|---|---|---|
| High School | 3 | 13.47 |
| Community College | 2 | 18.63 |
| Bachelors Degree (Ordinary) | 67 | 5.22 |
| Bachelors Degree plus Community College | 13 | 4.55 |
| Post-Graduate Degree | 14 | 4.55 |
| No Response | 1 | |
| | 119 | |

*(From survey carried out by Task Force in March 1987.)*

Counsellors also receive a nine-week training program when hired and are encouraged to upgrade their qualifications while at the board.

A close study of this training, however, emphasizes the futility of trying to teach basic skills and knowledge to a heterogeneous group of people in a brief in-house program. Most of the nine weeks is spent trying to explain the administrative structure and service delivery model within which they will work. In that same period, counsellors are also expected to learn enough about human behaviour in crises situations so they can intervene and help their clients. After this brief exposure to a body of knowledge that normally takes years to master, they are encouraged to learn more, but apparently little incentive is offered to do so.

The counsellors report that what little career advancement does occur is not based on knowledge or performance, but rather on personal relationships and "getting along" within the system. In the long run little advantage is taken of the opportunity to upgrade oneself, or even keep up to changes that are taking place, except by attending conferences as a passive audience.

Much has been written in standard textbooks about the role, qualifications and philosophy of rehabilitation counsellors, and the Task Force does not feel the need to repeat these in its report. However, it does feel strongly that the role of rehabilitation counselling must be redefined and standards set for counsellors that would establish their importance and prestige as case managers.

If rehabilitation is to help restore injured workers to satisfying lives, the people who deliver the necessary services should have the right to influence policy as well as the process of rehabilitation.

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*The training of vocational rehabilitation counsellors should require that all counsellors throughout the province meet certain standards to promote consistency in the quality of service throughout the province.*

Canadian Manufacturers Association
Toronto, December, 1986

❑ ❑ ❑

The Task Force has looked at the U.S. model and used it as a basis to design its own service delivery model.

Also by defining the rehabilitation counsellor as a case manager, the Task Force is asserting that case managers should be professionals who are knowledgeable and understanding of the needs of the community. They should have the freedom to design and carry through individualized rehabilitation programs that will help return injured workers to employment whenever possible and to a life of dignity and independence.

To achieve this goal, the Workers' Compensation and Rehabilitation Board must employ counsellors who have training in counselling, empathy towards persons with disabilities and knowledge of the workplace. These employees must recognize that each person is important, possesses human dignity and possesses the right to equal opportunity.

At the same time, the Task Force recognizes that many rehabilitation counsellors presently working at the Board do not have counselling training. In the U.S., the quality of counsellors is assured through certification, which has been in existence for many years. While the Canadian Association of Rehabilitation Personnel (CARP) has accredited rehabilitation workers since 1971, it is not on the basis of performance or training, but on the length of time worked in the field. Since the WCB encourages its rehabilitation counsellors to be members of the association, this is of interest for the development of a cadre of professional counsellors.

CARP is now proposing a new method of accreditation based on quality of experience, a set of skills and a philosophy of rehabilitation that is acceptable in our society. Those professing to become accredited would have to demonstrate their expertise through an examination. While this new proposal is only in the discussion stage at present, its acceptance would be a giant leap forward.

Therefore, the Task Force recommends:

52. That the Workers' Compensation and Rehabilitation Board provide time, funds and recognition for continuing education and upgrading of its rehabilitation staff so that they continue to maintain their skills.
53. That rehabilitation counsellors presently employed at Workers' Compensation Board be required and encouraged to upgrade their formal education to a graduate level in a program that stresses counselling skills.
54. That all personnel to be hired in the future at the Workers' Compensation and Rehabilitation Board as rehabilitation counsellors shall have training at a graduate level in programs that stress counselling skills. In exceptional circumstances, that recognition be given for work experience and that the board provide the time and financial incentives to train to a graduate level.
55. That the Minister of Labour work with the Minister of Colleges and Universities to actively promote the establishment in Ontario of a graduate level program that would train rehabilitation counsellors for certification.
56. That the Minister of Labour, in co-operation with representatives from

industry and community-based rehabilitation agencies, join with the Minister of Health and Minister of Community and Social Services to actively promote the establishment in Ontario of a system of certification of rehabilitation counsellors.

57. That the Workers' Compensation and Rehabilitation Board be required to provide onsite training at industries in the community so that rehabilitation counsellors maintain and enhance knowledge of the workplace.

## Caseload Size

One of the problems that repeatedly came to the attention of the Task Force was the size of the rehabilitation counsellors' caseloads. Complaints came not only from the counsellors themselves but also from employers and agencies that service WCB clients.

* * *

> *The Vocational Rehabilitation Services Counsellor of the Workers' Compensation Board in our area has a case load that is much larger than he can properly handle. In order that he cover his case load he cannot give any special treatment and cannot get really involved with his cases. Consequently the workers get turned off by these counsellors and it is sometimes very hard to get them back cooperating. Also, because his case load is so large, the counsellor is very reluctant to take in any extra claims before they are referred to him under the system.*
>
> Algoma Ore Division
> Sault Ste. Marie, October 21, 1986

* * *

It is difficult to solve the issue of caseload size because it is clear that to customize services to clients who have vastly different problems, unique programs that vary greatly in time and energy are required. Moreover, in non-urban centres of the province, especially in Northern Ontario, rehabilitation counsellors tend to spend more time travelling to meet with injured workers than in large urban centres.

Therefore, caution must be used in setting quotas on rehabilitation counselling. At the same time, the Task Force feels these overly heavy caseloads (especially in Northern Ontario) must be examined more closely.

In a questionnaire circulated by the Task Force in early 1987, field rehabilitation counsellors reported their average caseload size was 79.3 and they worked an average of 47.6 hours each week.

According to the 1985 annual report of Vocational Rehabilitation Services, the average caseload ratio had reached 75 and was reduced to 71 by 1986. However, as the following table will show, the figures obtained from the Task Force survey were considerably higher.

The distribution of caseload size across the province also varied greatly. The following table shows the distribution among field rehabilitation counsellors.

| **Caseload** | **Number** | **Caseload size** | **% of time travelling** | **% of time paperwork** |
|---|---|---|---|---|
| Toronto & vicinity | 45 | 77.0 | 19.9 | 38.6 |
| Northern Ontario | 11 | 104.6 | 19.4 | 43.8 |
| Western Ontario | 12 | 71.3 | 16.4 | 36.7 |
| Central Ontario | 6 | 68.3 | 24.2 | 25.0 |
| Eastern Ontario | 8 | 81.9 | 15.0 | 43.8 |
| Total | 82 | 79.3 | 19.5 | 38.4 |

The Task Force asked the Rehabilitation Counsellors what they would consider an optimum caseload and they indicated an average of 53 active cases.

* * *

> *Literature indicates that for the last 15 years, Rehabilitation Counsellors in North America have felt that the bureaucracies have been gaining at the professional's expense. An increased desire for accountability has meant the amount of paperwork has increased (studies show that the average percentage of time a Rehabilitation Counsellor spends counselling has dropped from 32% to 20% between 1969 and 1979), case reviews have become more focused on record keeping, statistics have increased dramatically to monitor individual and department success; and the ratio of direct service employees to supervisory staff has shifted from 10-1 in 1970 to 3-1 today.*
>
> CUPE, Local 1750
> Toronto, December 8, 1986

* * *

In a holistic program where purchase of service is emphasized and a case management approach is introduced, the role of the rehabilitation counsellor will change greatly from what it is now. The Task Force felt that caseload size would have to be monitored and would be expected to vary greatly with the nature of the work, type of client services and location in Ontario.

Therefore the Task Force recommends that:

58. That the caseload size of rehabilitation counsellors should be allowed to vary according to the amount of work each case requires, but should be set by management in consultation with the counsellors with due regard to the demands of a high quality of service and not allowed to rise above 50.

## Employment Specialists

The second category of staff in the rehabilitation team is that of employment specialists, which would include ergonomists and placement specialists.

As defined by the Task Force, employment specialists is a generic name for a set of staff members who would perform these and other functions.

Employment specialists should have knowledge and experience of the work world. They should keep abreast of changes in employment opportunities in their communities, shifts in demand and requirements in various occupations, and methods and style of work productivity. They should also maintain close contact with employers and organized labour and be aware of fluctuations and trends in availability of jobs and in the requirements of the workplace.

Employment specialists would have similar backgrounds to those clients they are serving, and wherever possible, have common ethnic, cultural and language ties.

Employment specialists are the front line workers who must communicate the board's program to employers and unions. They must also be the eyes and the ears of the board and be receptive to the attitudes and feelings of the general public.

Jobs to be performed by employment specialists are as follows:

- job placement
- creative job search
- maintenance of a job bank
- worksite modification
- work assessment and counselling
- contact with employers
- advising case managers in work assessment and rehabilitation areas

In large communities employment specialists may be hired who specialize in one of the many functions required of them. In smaller communities, fewer people may be available and one person may have to perform all of the functions of this group.

The Task Force therefore recommends:

59. That employment specialists be hired from among the working population in each community where a regional rehabilitation office exists to work with the case managers in formulating rehabilitation goals and programs.

60. That employment specialists shall assist in setting up retraining sites in the community and also assist injured workers in job search.

61. That employment specialists reflect the ethnic population of the workforce and be proportionally representative of the sectors of the injured workers population.

62. That these employment specialists be provided by the board with training from a qualified institution that offers educational opportunities in rehabilitation, job management or ergonomics.

## Chapter 8

# Early Intervention

- *10 reasons for early intervention*
- *injuries: visible and invisible*
- *definition of early*
- *a failure to communicate*

* * *

> *I'm on the Rehabilitation Program right now, but I haven't received... anything, like Toronto sent me nothing in writing. I went in... and told them at the Centre down here, I said, "Look, I got to do something, I got to at least try something, I just can't lay around like a vegetable" and I sold them on the idea that they should enrol me on this course, but they told me it's going to take six or eight weeks to get your file down, we can't do anything for you until we get your file. I said, "This is crazy, let me try the courses [that are] starting" and eventually, I talked my way to get onto the course, but I had to do all the pushing myself to get there.*
>
> Mr. Arnold Adams
> Injured Worker
> Kingston, November 18, 1986

* * *

> *Since rehabilitation services cannot intervene until after a claim has been awarded (sometimes months or years after injury) rehabilitation is often untimely and/or too late (e.g. persons become accustomed to inactivity: job intervention analysis and modifications cannot be done early on, thereby resulting in loss of jobs; timeliness of co-operative rehabilitation efforts with community professionals is jeopardized).*
>
> Ministry of Community and Social Services
> Ottawa, November 27, 1986

* * *

The phrase "early intervention" has become a slogan in rehabilitation. It is rare to find a rehabilitation program that does not expound the doctrine that early intervention is the preferred mode in rehabilitation.

This holds true for the Workers' Compensation Board of Ontario just as it does for many other boards elsewhere. As far back as January 1972, the WCB chairman wrote that the rehabilitation program should start as soon as possible after the accident. In response to the Standing Committee on Resources Development in March, 1987, the WCB stated:

* * *

> *The Board agrees that vocational training and education should begin early; studies to evaluate the effectiveness of early intervention are being contemplated. However, these initiatives must be kept flexible in order to enable counsellors to tailor programs to the needs of individual workers.*
>
> Workers' Compensation Board,
> Toronto, March, 1987

* * *

In fact, the WCB admits that the average lag time between the date of an injured worker's accident and his/her referral for vocational rehabilitation service has been 17 months.

But even this admission is open to question. For example, the Motor Vehicle Manufacturers' Association states:

* * *

> *The rehabilitation process should begin simultaneously with the treatment of an injury. Yet, in many instances, it is 18–24 months after the date of injury before the Rehabilitation Services becomes involved. Generally, the ease and rapidity of a workers' return to the workplace after an industrial accident is directly related to the length of his/her absence from the workplace. It is, therefore, imperative that the WCB Rehabilitation Services become involved sooner than they do now.*
>
> Motor Vehicle Manufacturers' Association
> Toronto, December 9, 1986

## *Ten Reasons for Early Intervention*

Based on a study commissioned by the Task Force, 10 reasons were cited for initiating rehabilitation services as soon as possible after the onset of a disability:

1. One can work with the disabled person and the family to prevent the development of psychosocial problems that could interfere

with the outcome of the rehabilitation intervention.

2. There will be less confusion for the patient, who can go through the process of coping and adjustment with guidance when needed.
3. Early rehabilitation lets the individual make a personal commitment to re-establish a sense of order in his or her life.
4. The feeling of being alone and abandoned can be decreased or prevented.
5. The person's level of motivation to recover can be stimulated and/or kept high.
6. Family members can be immediately enlisted to provide positive reinforcements to the disabled person.
7. One avoids the waiting period during which patients often begin to build up resentment towards the family, the medical profession, and the rehabilitation agency for delays in service.
8. The patient avoids the "runaround" or the feeling of being shuffled from one professional to another.
9. The secondary gains of being disabled can be kept in perspective.
10. Early intervention prevents the patient from settling into the sick role with the disability becoming a way of life.

But, while the positive qualities of early intervention can be speculated upon, little actual research into early intervention has been conducted.

* * *

*The WCB needs to focus on early identification and intervention for individuals who need rehabilitation services. To aid this goal, research needs to be instituted to help identify, early on, those individuals who are more likely to become chronically disabled.*

David T.Corey, Ph.D.
Behavioural Health Inc.
Toronto, December 10, 1986

* * *

The reasons for the failure to research early intervention may lie in the fact that the definitions of the words "early", "intervention" and "injury" are unclear.

The nature of the injury must certainly be an important factor in the determination of when to intervene. Work-related injuries in Ontario occurred 426,880 times in 1985 but in only half of these (48.5%) were allowed-no-lost-time claims made. The worker returned to the job with relatively little cost to the system. Of the remaining 188,461 incidents, 44.2% were allowed-lost-time claims. But again, generally the workers returned to their previous employment with no apparent after effects. Only in less than 6% of the allowed-lost-time work-related injuries reported in 1986 were the workers referred for vocational rehabilitation services.

But, as Livneh (1986a) points out, "the impact of a sudden physical trauma on an individual's life creates overwhelming physical, psychological, social, vocational and economic effects." This impact can be termed an invisible injury because its effects are subjective and cannot be assessed by objective means.

The Task Force is concerned that the introduction of rehabilitation not be guided only by concerns with the physical disability created by the accident or disease.

## *Injuries: Visible and Invisible*

Injuries generally have two components, visible and invisible. The visible component is apparent to external observers, either directly or with objective diagnostic instruments. Injuries that are mainly or entirely visible are easily diagnosed by medical practitioners and treatment is normally routine.

The invisible component, however, offers greater challenge. Invisible components cannot be assessed by objective procedures as they are subjectively felt. They include pains such as migraines and lower back and emotional stress-related traumas such as anxiety and depression. In fact, many injuries are entirely invisible and are not readily available for diagnosis. Many of the most difficult and unresolved files at WCB are those in which there is disagreement on the nature and extent of the invisible components of the injury.

While visible injuries are usually assessed quite readily with objective techniques and with fairly high agreement among medical personnel, invisible injuries are more difficult to assess, requiring careful interviewing and sometimes psychological diagnostic tests.

Moreover, just as secondary problems may develop with visible injuries, so invisible injuries can evolve and change their natures over time. Studies in the adaptation to disability (Livneh 1986b) have shown that an individual who sustains a traumatic injury may pass through a number of stages until recovery is achieved. During some of these stages, an individual is more motivated to recognize the effects of the injury and to initiate rehabilitation procedures than during other stages.

Clearly then, an individual who is assessing and monitoring the process must be able to appreciate the stages through which the injured worker is passing, and only then will he or she be able to intervene and initiate more successful rehabilitation.

The present tendency at the Workers' Compensation Board is to define early intervention in terms of a calendar yardstick — arguing that early intervention should be moved forward in calendar time.

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> *The length of time to contact a rehabilitation counsellor is far too long, the number of counsellors in our area is not sufficient to handle the caseload. For the employee the longer they are off the harder it becomes for them to return to the work setting. Many of them wait 6–8–10 weeks before being contacted by a rehabilitation counsellor or receive notification of an appointment at Downsview Rehabilitation Centre. This is when they have already been off 8–10 weeks.*
>
> Kitchener–Waterloo Hospital
> Employee Health Services
> Kitchener–Waterloo, November 24, 1986

❑ ❑ ❑

But the problem is that the WCB is dealing with months, and weeks and days instead of what goes on inside a person who has had a traumatic injury.

When the notion that the injured worker is passing through several stages of recovery — or failure to recover — is accepted, the position that early intervention really means "early monitoring" of the injured worker must also be accepted. The case manager must become aware of and involved in the entire recovery process, not only of the visible injury but invisible injuries as well. The injured worker should be visited in person as soon as possible after the traumatic event by someone trained and sensitive to the assessment of invisible injuries and able to intervene at the right moment.

## *Definition of "Early"*

The Task Force resolves therefore that "early" must mean the earliest possible moment. Too often the injured worker is left in a hospital bed, fearful of the extent and nature of the trauma and terrified at the prospects of a debilitating future. Treatment of invisible injuries cannot wait until Acute Health Care services are completed as normally happens today. Referral to rehabilitation must be made as soon as Acute Health Care defines an injury as serious. It should not wait until completion of all acute physical health care.

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> *The Committee believes that the early involvement of a worker with appropriate training in vocational rehabilitative care is essential in the initial assessment and subsequent rehabilitation of the injured worker.*
>
> Ontario Medical Association Committee on Rehabilitation
> Toronto, December 10, 1986

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The Task Force recognizes the need for trained and sensitive intake counsellors to become involved as soon as possible following a lost–time claim. Therefore, a claims officer must decide whether an injury is serious as early as possible after the event.

Yet, because of difficulties in diagnosis or communications, delays can occur. If assessment takes longer than 30 calendar days, the Task Force feels that the injury should automatically be considered serious and the worker should be automatically referred to a rehabilitation counsellor, acting as a case manager. In fact, if the injured worker is not back at work within 30 days, the injury should be deemed serious and the worker automatically referred to rehabilitation services.

The Task Force further recognizes that even among the WCB claimants who returned to their previous jobs, invisible injuries may have occurred which may have caused them to be handicapped in their psychological, social or economic conditions. To serve the injured worker better, the Workers' Compensation and Rehabilitation Board should be pro–active in offering rehabilitation assistance to those who need it.

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> *Injured workers should be involved with vocational rehabilitation at a much earlier stage. Too much time is lost between the date of the injury and entry into the vocational rehabilitation process. In addition to the physical and psychological benefits of such action, there is less likely to be frustration and ill feeling between the counsellor and the worker if there is quick access to the rehabilitation process. The worker with faith in his own increasing skills, in his counsellor and in the system has a much enhanced chance of success in re–entering the job market.*
>
> Ontario March of Dimes
> Toronto, December 11, 1986

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The Task Force therefore recommends:

63. That when workers are injured at the workplace or are discovered to have contracted a debilitating disease linked to the workplace, the following procedure, in partnership with the injured worker, be followed:
    a) The injured worker be provided immediate Acute Health Care Services.
    b) A claims file shall be opened at the nearest Workers' Compensation and Rehabilitation Board office.
    c) If the injury or disease is considered by Acute Health Care Services to be serious, or is a reoccurrence of the previous injury, or is reopened, Health Care Services shall notify the claims officer immediately who shall then transfer the file to an intake counsellor of the Workers' Compensation and Rehabilitation Board Rehabilitation Services for immediate initiation of rehabilitation services.
    d) If the injured worker is unable to return to work within 30 days, or if a file remains open for 30 days for whatever reason, the claims officer shall transfer the file to the intake counsellors of the Workers' Compensation and Rehabilitation Board for immediate initiation of services.
    e) All injured workers who are receiving rehabilitation services shall receive full benefits as long as they are receiving these services.
    f) Injured workers who have not been referred to rehabilitation services can request rehabilitation services and shall be referred immediately to the intake counsellor for service.

The Task Force has repeatedly noted that workers eligible for rehabilitation services frequently are unaware of their rights.

## *A Failure to Communicate*

The lack of good, open communication has contributed to a lack of trust and confusion among the WCB, the employee and the employer. This has created the present adversarial system instead of the more desirable co–operative system and gives the illusion that the WCB appears to have overlooked the reason for its existence in the area of rehabilitation.

The failure to communicate may be due to any of a large number of factors, and the Task Force has identified some of these in its interviews and submissions.

- language barriers
- failure by WCB staff to take a pro–active role in informing the client
- fear by injured workers of negative consequences if rehabilitation services are requested
- failure to listen to the client or to admit that the client may have hidden injuries

Reasons for the failure to communicate clearly lie in the WCB principles that rehabilitation services are a last resort and that money and paperwork can be saved if the client is denied services. But the Task Force feels strongly that goodwill of the injured workers will be obtained, complaints among the public will be reduced, satisfaction and morale among the staff will grow and, in the long term, money will be saved, if the Workers' Compensation and Rehabilitation Board takes a pro–active role in ensuring that the injured workers are aware of, and participate actively in the development of all rehabilitation services programs.

Therefore the Task Force recommends:

64. That the Workers' Compensation and Rehabilitation Board takes a pro–active role in contacting injured workers as soon as possible after the event, informing them of their rights and obligations and insuring that the injured workers fully understand their rights.

## Chapter 9

# Assessment

- *rehabilitation defined narrowly*
- *assessment and treatment*
- *the problems faced*
- *assessment definitions*
- *work assessment*
- *medical assessment*
- *psychosocial assessment*
- *vocational assessment*
- *work assessment*

* * *

> *I sat down in front of the lady and she says, "Okay, from your depreciation chart, you're only going to get this, this, this, this is how much your pension is going to be 5%, that's it." I said, "Well, I can't pay my house, I can't go to work; I have to be retrained and I've got to change my trade, yet you only classify me as 5%." They said, "Well, that's the chart...that's what you're assessed at. Goodbye." I spent two minutes with her. I mean, that's not right. They're talking about my livelihood for the next 40 or 50 years of my life and they spent a total of 6 minutes and 37 seconds. Now that's pretty bad.*
>
> Larry McRae
> Injured Worker
> Mississauga, December 12, 1986

* * *

> *We find that...the vocational part of the rehabilitation exercise seems to be at the bottom of the funnel, after everything else has occurred. And our own experience indicates that that's not very efficient. It's often too late. The person has been removed from the system too long before the vocational rehabilitation part starts. It seems to us that in a lot of cases, both the medical and the vocational should be concurrent efforts and they should be flagged just as soon as possible according to the nature of the injury and the process start in all fronts, not as a measure of last resort.*
>
> Mr. Jim Perry
> Chairman of the Ontario Mining
> Association Compensation Committee
> Thunder Bay, October 20, 1986

* * *

The stated goals and objectives of the Vocational Rehabilitation Department of WCB look good on paper. The philosophy of the department consists of three statements with which no one can quarrel.

1. a belief in a total (person) concept
2. a goal-oriented program
3. full participation of the injured worker

But examination of these three statements shows they are vague, indefinite and therefore useless. Nowhere is "total (person) concept" defined. What else could a program be except goal oriented? Including the participation of the person who is to receive the service is obvious.

The goals and objectives of the department are similarly defined so as to include:

1. the restoration of earning capacity;
2. effective and efficient vocational rehabilitation services;
3. early return to work and community.

Again, one would be hard put to argue against these goals and objectives.

On the other hand, examination of the underlying principles that guide service delivery shows that translation of the stated philosophy, goals and objectives into action is fraught with double messages, highly subjective interpretation and implied threats.

## *Rehabilitation Defined Narrowly*

Rehabilitation is defined in its narrowest sense with the return of the injured worker to the workplace rather than with concern for the worker's dignity.

Efficiency becomes important, but at the same time the system becomes top heavy and flow through the system is slow. Injured workers fall through the cracks if they don't know their way around. They can never be certain of the type and quality of service they will obtain or who at the Board is responsible for them.

Counsellors receive double messages. They are instructed to rehabilitate the injured workers but at the same time close cases rapidly and concentrate on paperwork. They are challenged to do their best but are not taught how to do it and, more importantly, don't know what the board wants them to do. Moreover, interviews with counsellors give the impression that as long as a counsellor manages to keep up to acceptable levels of closures in the various categories, allowances can be made for the design of individualized, quality service for some injured workers.

Today, the primary function of the Vocational Rehabilitation Department is to process injured workers through a system that receives them after Acute Medical Care is completed or nearly completed and returns them to the same job or a similar one. There is little concern with their dignity, their quality of life or that they will continue to fall further behind their co-workers in income.

Injured workers are led to expect that they must indeed suffer because of the accident and should be grateful for any service they obtain. Most of the workers interviewed stated they were made to feel that they were partially or entirely to blame for their present situation.

So the situation can be described as one in which there are published guidelines and underlying precepts. One face is presented to the public — a face of competence, efficiency and quantity of service.

But another set of goals really drive the system give enough to placate the injured worker, taking into account the nature of the accident, the amount of disability, his or her characteristics and the need to show improvement in the statistical records over the past year.

It is therefore important to examine the nature of the complicated process of rehabilitation, to see what services are being offered and what could and should be made available to injured workers.

Since this report cannot serve as a textbook of rehabilitation it will attempt to touch briefly on its various aspects.

## Assessment and Treatment

The process of rehabilitation can be divided into two different stages: assessment and treatment, recognizing that the two are frequently conducted simultaneously in the same location. The goal of assessment is to obtain information that will direct the treatments or interventions toward their various goals.

Assessments and treatments can also be divided into three areas — medical, psychosocial and vocational. Medical rehabilitation, consisting of assessment and intervention is concerned with the physical impairment and disability of the client. Psychosocial rehabilitation is responsible for reducing the emotional impact or "handicap" on the client and the client's family, providing a social support group and restoring their economic well-being and daily functions. Vocational rehabilitation helps the client return to some form of employment, the type and level of which must be determined through assessment and work adjustment training.

It is not surprising that injured workers are unaware of the complexity of the rehabilitation process, of the great variety of procedures and the need to tailor each program to the individual. Many counsellors know how complicated the system is and are able to develop suitable, individualized programs. Other counsellors, for whatever reason, set up patterns of service delivery and tend to follow them rigidly, regardless of the client's specific needs.

## The Problems Faced

In examining the current rehabilitation process of the Vocational Rehabilitation Division, several problems must be faced.

1. The system is slow. It takes a great deal of time to move an injured worker through the process. Things that could be handled at the same time are usually performed consecutively, frequently because no one person takes responsibility for a client.
2. Clients fall through the cracks and don't get the services they need, in part because no single counsellor is responsible for the client and counsellors must fill their quota of closures.
3. With duplication of files and different people located in several offices handling varied aspects of the case, communications becomes a contributing factor to cost and quality of service delivery.
4. Counsellors are hired who have never developed the skills of assessment and

intervention and do not understand the demands and requirements of the workplace. Once on the job they do not keep current in their field or develop their counselling skills.

5. Counsellors are given double messages — "supply quality rehabilitation services but keep costs down." While statistics look good, clients are frequently dissatisfied.
6. Often services are unavailable in the local community. The WCB does not invest time, energy and money to help the community develop them. When the board does offer these services itself, it often does it poorly, as the Review Team that investigated Downsview Rehabilitation Centre showed.
7. The system favours injured workers with the greatest chance of becoming re-employed the English-speaking, young, well educated and married clients.
8. The board has developed a number of ineligibility criteria which either limit or restrict access to vocational rehabilitation services. The two most obvious policy procedures which deny or curtail vocational rehabilitation services are when:

An injured worker fails to accept suitable employment which is available and which is determined to be within the worker's skills, capabilities and aptitudes.

An injured worker has received extensive vocational rehabilitation services without benefit, and there is no evidence to indicate a change in the client's response to counselling or a willingness to co-operate.

If we exclude the No Further Rehabilitation Action indicated (NFRAI) categories of "returned to school", "deceased", and "withdrawn", we see that in 1986, 35% or 3,554 of the 10,101 vocational rehabilitation service completions were closed as a result of the WCB curtailing rehabilitation services on the assumption of non-co-operation.

The major problem with these ineligibility criteria is that they are entirely arbitrary, and their discretionary application could have a significant adverse impact on the re-entry of injured workers in the workforce.

9. Apart from the problems mentioned, the WCB may also be in conflict with the Human Rights Code, so that the application of these ineligibility criteria could have legal consequences.

## *Assessment Definitions*

A large number of terms exist in the rehabilitation field to describe the complex process that is required to assess an individual's ability to take and hold a job. Many of these words are arbitrary, misunderstood or have different implications for different people. Therefore, it is appropriate at this point to define some of them for the sake of clarity.

**Medical Assessment** refers to an evaluation by a physician and/or a designate to assess the individual's degree of impairment.

**Physical or functional assessment** is an evaluation by a physician and/or a designate to ascertain the extent of a disability and degree of body function loss. The physician may normally be a physiatrist and the designate a physical therapist or an occupational therapist.

The worker will be asked to perform certain actions which will reveal how much the disability will limit him or her. For example, a functional assessment may indicate that the grip strength of an individual's right hand won't allow the worker to hold a steering wheel. Another test might indicate that his or her eyesight is too poor to distinguish complex forms.

In the development of a rehabilitation plan, this kind of information can be vital.

**Psychosocial assessment** refers to an evaluation by a psychologist, social worker or psychiatrist, to determine how badly the worker has been affected or "handicapped" by his or her impairment or disability. Examinations may include psychological tests and interviews.

The assessment may identify areas in the individual's life which are creating barriers to rehabilitation. The impact of the injury may have had a traumatic effect on the worker's self-image, so that the worker believes he or she is incapable of performing similar work again.

For example, the head of the household has lost status within the family alienating them from his or her spouse and children. Such conditions are hidden injuries and may be as limiting to successful re–employment as are the physical, visible injuries.

**Vocational Assessment** refers to an evaluation by a rehabilitation worker of the strengths and weaknesses in an individual's vocational plans. The assessor may be a psychologist, but just as frequently is someone trained in vocational counselling.

Psychological tests directed towards vocational assessment will normally include personality inventories, intelligence tests, interest batteries and aptitude and achievement tests. Non–psychological tests may include aptitude tests and work samples, such as VALPAR and TOWER.

Vocational assessment is focused closely on the work to which the client will be referred and measures the strengths and weaknesses of the worker's physical and psychological readiness to choose an occupation, enter it and retain it.

## Medical Assessment

When the injury is serious, the first time the case manager will probably become involved is during the medical and functional assessments following Acute Health Care. At this point the client may have been assessed at a hospital and/or by the family physician. When the diagnosis is clear and uncontested, the case manager can assimilate the information and make the necessary plans for medical and physical rehabilitation.

However, this diagnosis and subsequent recommendations may be in conflict with that of another physician consulted by the Board, the employer or the injured worker. At that point the case manager would request the Ontario College of Physicians and Surgeons to appoint a specialist to judge the dispute.

Therefore the Task Force recommends:

20. That where a dispute arises among medical practitioners regarding the diagnosis and functional assessment of the injured worker, the case manager shall request the Ontario College of Physicians and Surgeons to appoint a specialist to adjudicate the dispute.
21. That adjudication shall take place within 30 days of notification of the existence of the dispute and that the results shall be given to the case manager.
22. That during the period of review by the adjudicator full financial benefits shall be continued.
23. That should no agreement in diagnoses then be obtained, or the worker or employer refuse to concur with the outcome, the case may be taken to the appeals system.

## Psychosocial Assessment

At present, assessment by psychologists, psychiatrists and social workers is purchased on an *ad hoc* basis. Determination of purchase is made by the medical rehabilitation personnel or by the rehabilitation counsellor.

Little change is contemplated in this area except in regard to two points. First, the case manager, rather than the medical practitioner should be the one who makes the referrals and receives the reports for psychosocial assessment. Second, with a holistic definition of rehabilitation, the need for assessment could be more frequent, reflecting a greater sensitivity to invisible injuries.

## Vocational Assessment

The purchase of vocational assessment from psychologists and the private sector should continue in the future but with greater regard to input from the employment specialists.

Essentially, the Task Force believes that many of the activities now conducted at the WCB should remain with few alterations. But the change that should occur must be in the direction of the new principles and guidelines: a holistic definition of rehabilitation, a greater involvement of the client in decision making and more concern and sensitivity towards the needs of the injured worker.

## Work Assessment

**Work assessment** (dealt with in greater detail in the next chapter) is conducted with actual work and measures the degree to which an individual can be successful at a particular job, as opposed to a vocation. In practice it is carried out in environments that most closely resemble the actual work that is expected to be performed. Assessment should therefore be made at the site under working conditions or, if that is impractical, simulated work sites where the job is performed under the direction and evaluation of a trained supervisor.

For instance, the ability to perform janitorial work is evaluated by contracting the worker with a company that provides these services. Another example might be one in which an assembly workshop is created to test the individual's ability to work successfully at an assembly job.

Work assessment should be a way of helping a client who has difficulties in formulating a work plan or one who is anxious about readopting a worker role after a long recovery period. Today, unfortunately, it is a way out of a dilemma by desperate counsellors who cannot think of other solutions.

Frequently workshops are established which take contracts for such jobs as parts' assembly, packaging and labelling where individuals can demonstrate reliability, concentration, positive motivation, punctuality and quantity and quality of work output. Such work assessments are generally performed in shops run by non-profit agencies, such as Jewish Vocational Services, Goodwill and COSTI.

Determining the strengths, weaknesses and limitations of an individual's ability to work is a complex process and must be orchestrated so that all the elements work in harmony. Frequently, one group of assessors will argue that what they do is the most important part of the rehabilitation process or that they are best able to perform most of the functions. However, the best analogy is that of the orchestra where the most satisfying music is obtained when all the elements are playing their own parts in harmony with the other parts of the orchestra.

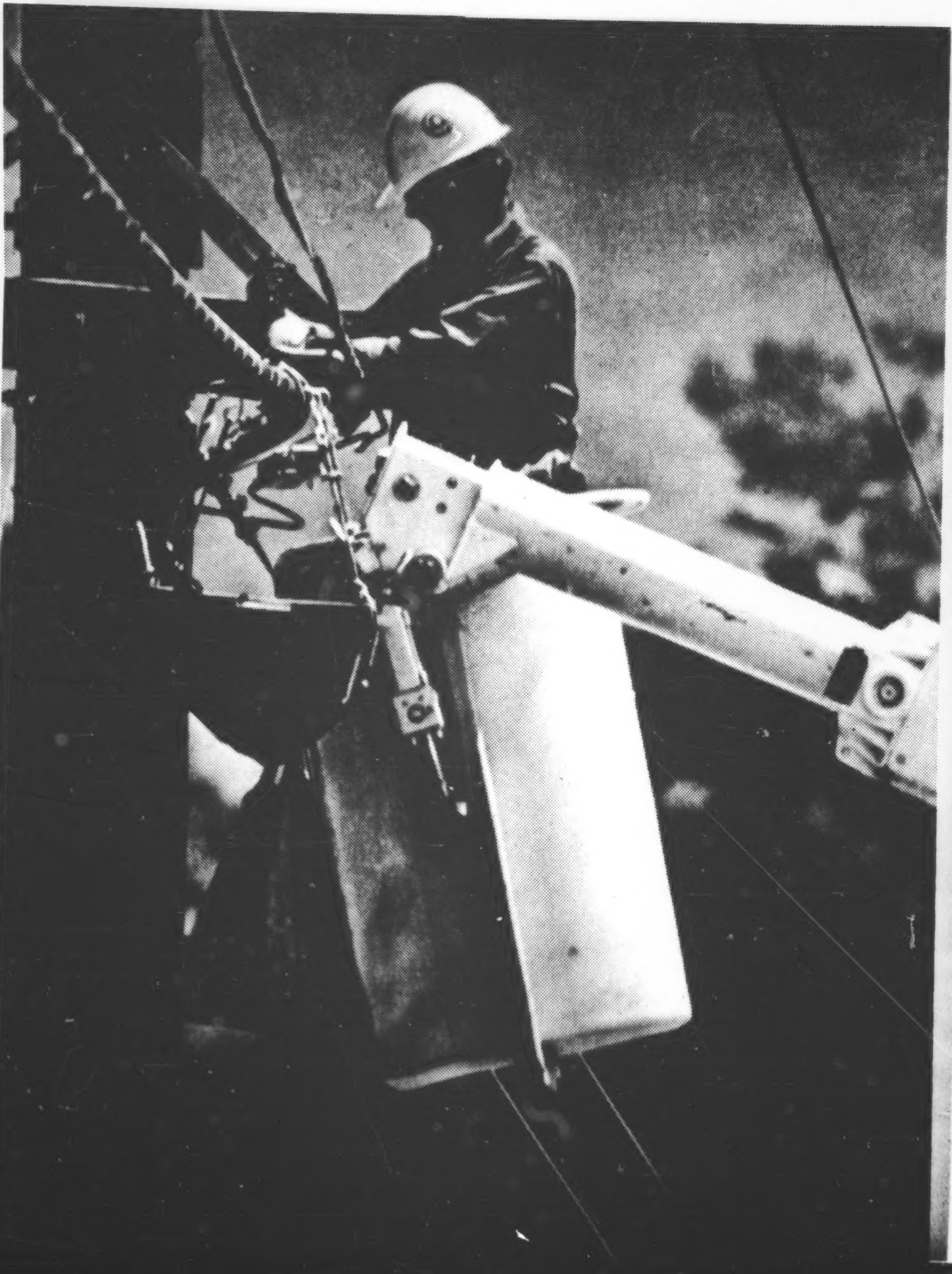
The conductor of this "Rehabilitation Orchestra" is the case manager who must identify the elements that perform, the time of their performance and the way in which they will integrate and harmonize with the rest of the orchestra. While the case manager need not be an expert in any of the instruments, he or she must know enough about all of them to determine their appropriateness and limitations.

Therefore the case manager must be able to choose the appropriate services and the agencies and individuals to deliver them. Selection should be made from agencies and individuals who can demonstrate effective delivery of service by being licensed or accredited or have an objective, evaluative component which is public.

The case manager must therefore seek information from all appropriate sources and, together with the client, determine an appropriate rehabilitation program. Each program is individualized and fits that particular client's needs.

The Task Force makes the following recommendations:

24. That the Workers' Compensation and Rehabilitation Board take a pro-active role in working with the community to reduce environmental barriers to the employment of people with physical or emotional injuries.
26. That the Minister of Labour initiate and co-ordinate efforts among the provincial and federal government, management and labour to establish sector-based skill training centres in appropriate areas of the province open to all people requiring skill training.
27. That the management of the sector-based rehabilitation centres be constituted with labour and management, or, where labour is not organized, with rehabilitation practitioners and worker representatives from the community.



## Chapter 10

# Work Assessment and Work Adjustment Training

- *rehabilitation workshops*
- *three kinds of assessment*
- *work assessment*
- *competitive employment*
- *supported work programs*
- *enclaves*
- *community–based centres*
- *sector–based centres*
- *segregated employment*
- *workers perceived as malingerers*
- *no employment*
- *appeals procedure*

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> *[I'd like] re-training of some sort, because, you know, I'm more or less just rotting [away] right now, sitting around doing absolutely nothing, when I could be learning something. I do have some skills other than factory work, but since I've been employed in a factory for seven and a half years, it's kind of hard to get back into anything else. People don't want to take a chance on you, especially if you've been on compensation.*
>
> Elmer Moroun, Jr.
> Injured Worker
> Windsor, November 6, 1986

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> *An example of when the Board has abandoned their responsibility to the injured worker is of a client of ours who began on a training program sponsored by the Board, a "Women in Technology" course, and halfway through it, was declared fit to return to regular work, and at that point, the Board stepped in and said, "Okay, no ongoing disability. Sorry, goodbye. It's your problem now, so get Manpower assistance, whatever." Needless to say, she's not in the course anymore.*
>
> Ms. Katrine Perrera
> Union of Injured Workers
> Legal Clinic
> North York, December 11, 1986

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While 1985 WCB figures show that 23% of all active cases in the Vocational Rehabilitation Division (4,499 of 19,548) began some form of assessment and 13% (2,614) started training, the type or quality of programs, their direction and type of clients chosen for each are unknown.

The most likely candidates for work assessment programs seem to be older workers, usually in their 40s or 50s, with no job skills apart from those acquired during their working years. These workers might have been construction labourers, steelworkers, garment workers, miners or forestry workers, whose main assets were a strong back and an abundance of physical energy. Typically, these workers, especially in the urban centres of Southern Ontario, speak little English and have minimum education.

Under the current system, the outcome of an assessment will determine whether the injured worker will continue to be serviced by Vocational Rehabilitation. A poor assessment usually leads the Vocational Rehabilitation Counsellor to conclude the injured worker is competitively unemployable.

No further rehabilitation services are offered, and financial assistance in the form of pension supplements or vocational rehabilitation benefits under Section 54 of the *Workers' Compensation Act* are stopped. With some pleading or help from influential people, the injured worker might persuade the counsellor to "give him/her another chance" and a new assessment arranged. However, in many cases the worker simply accepts the assessment as it is and gives up.

## *Rehabilitation Workshops*

One question that must be examined is whether rehabilitation workshops that are traditionally used by the WCB serve the needs of the injured worker.

Rehabilitation workshops generally combine assessment and retraining facilities in the same area. Many of them also include segregated employment services, that is, sheltered workshops. They offer services to people with severe physical or emotional disabilities who may never have experienced regular competitive employment.

Such an environment may be debilitating to workers injured on the job who have had years of experience in bricklaying, welding and machine servicing. Packaging washers or labelling boxes may be demeaning to these clients, particularly since the tasks were designed for people who have had little or no experience in competitive work, people who are retarded or emotionally fragile.

Injured workers placed in a segregated workshop complain that the work is boring and tedious. They do not understand the reason they are there and when it is explained, balk at the need to be assessed on such basic factors as "ability to concentrate" and "reliability". So they lose interest, their productivity diminishes and they are frequently absent from work. This leads to a negative report and the counsellor concludes that the injured worker is a malingerer.

In theory, on successful completion of a work adjustment program, the worker should be ready for some employment, likely at a lower entry level job. In reality, success rates, as measured by placement in competitive employment, are extremely low. The Ministry of Community and Social Services, the major funding source for workshops, has estimated that less than 6% of workshop participants are placed in competitive employment. Serious concerns are raised about the adequacy of these programs and whether they do in fact prepare individuals for competitive employment.

In a study commissioned by the Task Force of 33 agencies that supply workshop assessment and work adjustment training in Ontario, 20 reported that they regularly received referrals from the WCB. These agencies reported that WCB clients tended to be older and somewhat less-educated than the average agency clients. Problems associated with WCB clients included unspecified back pain, joint injury, social-emotional problems, literacy problems, low motivation and few transferable job skills. They were perceived to be more frustrated, angrier and less enthusiastic than the average client.

These data seem to confirm that WCB clients are being referred to segregated workshops with little regard to whether the atmosphere in the shop, the other employees and the type of job offered are appropriate to their needs.

## Three Kinds of Assessment

There are three types of assessment which are paid for by the WCB: controlled environment, industrial setting and psychological.

**Controlled environment assessments** are used to determine an injured worker's physical restrictions and occupational capabilities. Most programs are eight weeks long and take place in a sheltered workshop within a social service agency.

Controlled environment assessments accounted for 71% of 1986 expenditures on assessments. The amount of money spent almost doubled in the period 1983 to 1986 while the actual number of programs begun over the same period grew by only 59%. This would indicate that the per-capita costs of such assessment are growing. Looking at a longer period, however, it appears that controlled environment assessments are the fastest growing in use of all programs offered as a tool for vocational rehabilitation. Between 1981 and 1986, the number of such programs started grew from 693 to 1,618, a 233.5% increase.

**Industrial-setting assessments** are about six weeks long and take place in an actual work environment at no cost to the employer. As they are most commonly used for essentially work-ready injured workers, they may lead to training-on-the-job and/or placement of the worker with the employer.

Industrial-setting assessments represent the smallest share of expenditures in this category, accounting for only 1.6% of all payments for assessment services. Payment for these programs *dropped* 71% between 1983 and 1984, but have risen somewhat since then. No similar reduction occurred in the number of people involved, however from 1981 to 1986 the number of programs started grew by 52%.

Though the number of injured workers who were referred for **psychological assessments** is unknown, it represents a large and rapidly growing outlay of Section 54 funds increasing by 120% since 1983. In 1986, over $600,000 was spent on psychological assessments (costs of DRC not included), accounting for 27% of all assessment expenditures. The 1986 amount is an increase of 120% since 1983. However, when one takes into account the expense of such services at the Downsview Rehabilitation Centre, it is clear that even these large reported increases are an underestimation of true expenditures on psychological assessment costs.

Assessments are used extensively to determine whether the injured worker continues to be eligible for vocational rehabilitation services. Poor assessments generally lead to the conclusion that the injured worker is competitively unemployable due to "self-imposed restrictions" which are either compensable or non-compensable. In such a case, no further rehabilitation services are offered and financial assistance in the form of pension supplements and Section 54 benefits are stopped. If the assessment is favourable, a training-on-the-job program or direct placement becomes the goal of Rehabilitation Services.

## *Work Assessment*

A work assessment is usually seen as a last effort to determine the employability of a worker who has been off work and receiving compensation benefits for an extended period. As the data suggests, an increasing number of these assessments are conducted in sheltered workshops at various agencies rather than in industrial settings. The criteria used for the assessments are devised by the workshop operators, without input from the Vocational Rehabilitation Division, and therefore vary among agencies. Work assessments typically include measures of productivity, attendance, cooperativeness, ability to follow instructions and subjective impressions about motivation and attitude.

In general, injured workers are assessed in agencies which do not provide services targeted to the needs of experienced workers who have sustained injuries. In those agencies with WCB referrals who responded to the Task Force questionnaire, injured workers only accounted, on average, for 25% of the client base. The average age of clients in these agencies is 37, with 95% of the client base younger than 44 years old. At least in terms of age, this does not match the demographic profile of injured workers who are receiving vocational rehabilitation services.

Most assessment programs developed in these facilities focus on situational assessment, work experience or vocational evaluation. Functional assessments are less common in agencies which receive referrals from the WCB. In terms of training, the most widely used program is basic work-adjustment training. These programs focus on reacquainting the injured worker with such concepts as punctuality, ability to co-operate with co-workers and supervisors and follow instructions. The common denominator in all these programs is that participants perform simple repetitive tasks, tasks designed primarily for lower-functioning individuals who have had little exposure to a competitive setting and have had no work history.

There is no indication that these programs help the injured worker's vocational rehabilitation or re-entry into the labour market. The WCB keeps no statistics on the success rates (as measured by permanent placement in competitive employment) of injured workers who have participated in these programs. However, the Ontario Ministry of Community and Social Services, the major funding source for workshops, estimates that less than 6% of workshop participants are placed in competitive employment.

The WCB must provide creative solutions for work assessment and work adjustment training. A large number of innovative programs exist in Canada and in the rest of the world from which the WCB could choose to sponsor or help to create.

In an excellent review of existing employment alternatives for workers with disabilities, Bordieri (1986) uses Vash's model of a "Hierarchy of Employment Options" to discuss a number of existing programs in North America and Europe.

**Hierarchy of Employment Options** (Vash, 1977)

| | |
|---|---|
| **Level VI** | Competitive Employment — No accommodation or shelter |
| **Level V** | Fully Integrated Employment in Mainstream Industry — some accommodation or shelter |
| **Level IV** | Employment in Semi-Integrated Units in Mainstream Industry — significant accommodation or shelter |
| **Level III** | Employment in Segregated Workplace Hiring Predominantly Disabled Workers — the prototypic sheltered workshop |
| **Level II** | Homebound Employment |
| **Level I** | No Employment — at home or in institution |

He first presents Vash's model, reviews employment policies for disabled workers and then identifies innovative programs that offer services at each level.

## *Competitive Employment*

Vash's (1977) Level VI of employment represents competitive work in industry for the disabled person without any accommodation or shelter. Competitive employment for handicapped workers is greatly emphasized in the United States yet few national policies exist to promote disabled workers into the open labour market. Internationally one finds quota systems, government grants, wage subsidies and tax credits to employers as examples of government policies and initiatives that attempt to get disabled workers employed in open industry.

## *Supported Work Programs*

It has been argued extensively that rehabilitation is based on the assumption that a disabled person must have certain "pre-vocational" skills before being considered for competitive placement. As a result, many severely disabled individuals who lack these skills have been denied access to mainstream industry. These people find their major vocational alternatives in rehabilitation facilities.

However, advocates for supported employment programs disagree with the need for these "pre-vocational" skills.

Instead, they offer a very labour-intensive, step-by-step approach for achieving competitive placement. The supported work model places the disabled person in open industry, provides extensive job-site training and ongoing assessment, and, when necessary, receives job retention assistance from a counsellor. This model emphasizes a "place-train" approach to competitive job placement as opposed to the traditional "train-place" philosophy of vocational rehabilitation.

The labour-intensive aspect of supported work programs relates to the role of the rehabilitation counsellor. Each counsellor goes directly to the employer and identifies potential jobs for the disabled client before the employer meets the applicant in a well-rehearsed interview. The counsellor's role does not end with job placement, however. He or she remains involved with the employer and client on an as-needed basis to ensure successful work performance. Each job placement requires the counsellor to deliver on-the-job training to each disabled worker. Behavioural techniques are also used to teach the client to do his or her job more effectively.

## *Enclaves*

At Vash's Level IV of employment, the disabled worker needs significant accommodation and shelter to maintain a job in semi-integrated units of mainstream employment. Vash has defined this employment option for a disabled person as an enclave in industry. According to Vash, this program type, unlike the sheltered workshop and affirmative industry models, "attempts to minimize duplication of effort and overhead costs by maximizing the usage of industrial sites, equipment and resources".

Some writers have referred to this employment alternative as work crews, job worksites, workshops-without-walls, work stations and satellites. Although each term may have a slightly different connotation, the basic concept of a small group of disabled workers in an industrial setting is evident from descriptions of these programs.

Generally, a section of the job site is set aside for workers with disabilities and they are paid either directly by the employer or through subcontracts with the rehabilitation facility. European enclaves are thought of as full-time, permanent employment, while in the United States they are seen as transitional places to work until competitive placement can be achieved.

## *Community-Based Centres*

From a review of the Bordieri paper one might get the feeling that innovative rehabilitation programs exist everywhere but Ontario. However, at least in Toronto, the community-based centres have innovated and developed similar programs to those in other countries.

If these programs have failed to make an impact on rehabilitation in general it is because the government has failed to assist in the innovative spirit to a sufficient degree. Few programs exist in Ontario outside of Toronto and even in Toronto the programs of Goodwill, JVS, LIUNA, March of Dimes and COSTI, among others, are continually strapped for funds and can't offer the kind of quality programming they want to maintain a sound financial base.

Unfortunately, community-based centres that do exist in medium and large communities of Ontario are poorly equipped, due to lack of funding, to assess work readiness and perform the function of work adjustment training or work hardening. They are normally established by the private, non-profit sector of the community.

Not every community has a workshop and in these cases, the Workers' Compensation and Rehabilitation Board would normally purchase such services in the closest community where they are provided. Furthermore, although the Ontario Rehabilitation Work Council keeps a record of all existing workshops and has developed accreditation guidelines for performance, the actual services of the workshops are not monitored and they are not required to follow the guidelines.

Therefore the Task Force recommends:

28. That the Minister of Labour, in co-ordination with the Minister of Community and Social Services, and in co-operation with representatives from industry and community-based rehabilitation agencies, initiate the development of accreditation standards for rehabilitation workshops and activity facilities in Ontario.
29. That accreditation standards should be put into place within two years of receipt of this recommendation.

To ensure that accreditation standards be maintained, the Task Force recommends:

30. That Workers' Compensation and Rehabilitation Board refer clients for assessment and work adjustment only to those workshops that are accredited and can demonstrate an evaluation process to monitor their quality of service.

## *Sector-Based Centres*

Following the principles of re-employment stated by the Task Force, it follows that work assessment should first be found in the industry where the worker was previously employed. To this end, the larger industries of Ontario should be encouraged to provide worksite analysis to assess the extent to which a worker can return to a job within the industry.

The purpose of a sector-based centre is to perform work assessments and rehabilitate an injured worker as much as possible within the industry itself. One can identify a number of large industry sectors such as mining, construction, automobile manufacturing and lumbering in which accidents take place and workers are injured on the job. The Task Force feels that it is the industrial sector's responsibility to develop programs that will return the injured worker to the workplace. This holds true for worksite modification and for the development of sector-based centres in communities where industries are located.

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*The initial rehabilitation efforts should be conducted in the injured worker's normal workplace setting for the following reasons:*

*a) Too much emphasis is placed on telling injured workers what they* cannot *cope with, instead of permitting them the opportunity to demonstrate what they* can *cope with.*

*b) In many instances, injured workers find that they are capable of returning to normal work functions or, isolated restrictions in normal work functions acceptable to the employer and the worker.*

*c) A return to normal or restricted work functions in a competitive work setting as compared to a sheltered work setting should be the foremost objective. This is particularly crucial in industries where employment opportunities are influenced by seniority rights and obligations governed by collective agreements. A return to work in a competitive work setting therefore enables the injured worker to exercise his rights within the collective agreement to apply for training in jobs other than his own, or be placed in work functions better suited to his physical abilities.*

*d) In the event that the injured worker demonstrates he cannot return to work with the accident employer, the results of the workplace assessment should be of value to the Vocational Rehabilitation Services in placing the injured worker in a vocation best suited to his/her capabilities.*

Ontario Chamber of Commerce
Toronto, January 23, 1987

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Where collective agreements exist within industry, both labour and management should be directed to protect the needs of injured workers and assist in developing and managing the sector-based centres. Where the work force is not organized, the community should participate in their development and management. The characteristics of sector-based centres as seen by the Task Force are as follows:

- Sector-based centres should be located on or close to the worksite as possible so that workers will not be removed physically and psychologically from their place of employment
- Sector-based centres should provide work that is as close to the task performed in the industry as possible
- Where appropriate, sector-based centres should place injured workers for assessment and work adjustment training on regular jobs in the industry
- Staff at sector-based centres should be experienced in the industry and be trained as rehabilitation and vocational counsellors

The Task Force therefore recommends:

24. That the Workers' Compensation and Rehabilitation Board take a pro-active role in working with the community to reduce environmental barriers to the employment of people with physical or emotional injuries.

26. That the Minister of Labour initiate and co-ordinate efforts among the provincial and federal government, management and labour to establish sector-based skill training

centres in appropriate areas of the province open to all people requiring skill training.

27. That the management of the sector-based rehabilitation centres be constituted with labour and management, or, where labour is not organized, with rehabilitation practitioners and worker representatives from the community.

## Segregated Employment

At Vash's Level III of employment, the disabled worker is found in the traditional sheltered workshop, segregated from mainstream competitive employment. Few able-bodied workers are found in this setting, and the sheltered workshop is largely subsidized by external funding to assure its existence.

While there are many disadvantages to sheltered workshops, there are also examples of those that have met with success. In Halifax, three levels of government and the business community joined forces to create the Human Resources Development Association (HRDA) in 1978. The HRDA's goal was to provide long-term, meaningful employment to those who subsisted on welfare, such as single parents, the mentally and physically handicapped and others who had special problems competing in the labour market. Since then, the HRDA has established such varied ventures as a car-rental agency, appliance service and repair, property management, job placement, carpet dyeing and parachute making.

In the United States, Abilities, Inc. has been touted as an example of excellence for segregated employment of the disabled. Offering sheltered employment to more than 100 disabled individuals, Abilities Inc. has major contracts with the Equitable Life Assurance Society of the United States, IBM, New England Bell, Sperry Gyro, United States Department of Defense, and the Westinghouse Electric Corporation, to name only a few. The chief areas of operations are electronics, telecommunications, data processing, and other clerical and industrial tasks. A gift shop is also in operation which realizes $30,000 per year.

In conjunction with the other divisions of its Human Resource Center, Abilities Inc. conducts rehabilitation programs designed to place disabled workers in competitive industry. Its placement services work very closely with more than 150 companies in the surrounding area to establish working arrangements to hire severely disabled workers. Human Resource Center staff also provide extensive follow-up services to both client and employer to ensure satisfactory results.

Another successful Abilities, Inc. program exists in New Zealand. Started in 1959, Abilities currently operates with a staff of 70 people on the north shore of Auckland. The almost exclusively disabled work force receives wages comparable to general industry. Although technically a sheltered workshop, Abilities, Inc. provides a normal business environment with emphasis on profit making. The work is balanced in complexity in order to be suited to all levels of disabilities.

Contracts range from simple packaging and assembly operations to complex electronics manufacturing. The profits and revenue generated from existing contracts are used for project expansion. Abilities, Inc. is currently implementing a new centre to offer vocational opportunities to severely disabled individuals and exploring the feasibility of starting a self-supporting horticultural project.

In Europe, Poland's Invalids' Cooperative Union is considered by Vash to be the most sophisticated model of segregated employment. Over 200,000 disabled citizens, representing 30% of the disabled population of Poland, are served in the cooperatives. The Union has 435 enterprises which employ 288,000 people, and the law requires that 70% of the workers must be disabled. According to Vash, each enterprise is operated according to the rules and regulations established by the national union and each member has a say in management issues.

The rehabilitation staff includes a physician, physical therapist, social worker and recreational therapist. Services include medical rehabilitation and vocational adjustment and training. Some programs focus on job modification, independent living and rehabilitation engineering.

Disabled workers earn the same wage as their able-bodied colleagues in co-operatives which manufacture more than 150 industrial products such as electrical equipment, textiles, plastics, footwear and rubber products. Additional revenue is produced through repair and property-guarding services.

England's Reemploy, Limited offers another example of government subsidized, segregated employment for disabled workers. Reemploy was established in 1945 to provide training and employment to disabled veterans by the *Disabled Persons' Employment Act*. Receiving funds from the British Department of Employment, Reemploy currently operates 94 production units that manufacture and offer such products as furniture, leather goods and textiles, and services such as packaging and assembly. It has about 8,800 disabled workers and 2,400 able-bodied workers on staff.

The only sheltered workshop element within Reemploy is that disabled workers who all belong to a union have uncontested job security as long as they adhere to company rules and regulations.

It seems that sheltered workshops in Europe do not function as social service agencies but instead take a very business-like approach to their operations. Compared to the United States, the sheltered workshops in Europe:

- tend to be larger
- utilize more modern technology in their operations
- pay workers competitive or near-competitive wages
- provide workers with typical fringe benefits found in industry
- tend to be more integrated with disabled and able-bodied employees working together
- emphasize long-term rather than transitional employment

Sheltered workshops in the United States are perceived as places for transitional employment until competitive placement can be obtained. In contrast, European workshops are viewed as permanent, full-time employment for the vocationally handicapped worker.

## *Workers Perceived as Malingerers*

Sometimes WCB staff get injured workers back to work by threatening to cut off their benefits. Time and again injured workers related tragic stories of how they were cut off benefits because they couldn't find work on their own. These were workers who had spent years at blue-collar jobs, with families to support. The frustration and humiliation endured by injured workers was appalling and created a sense of anger among the members of the Task Force who heard these agonizing recitations daily.

Hundreds of telephone calls came to the Task Force office from injured workers who could find no other way to air their grievances. They were filled with shame, anger and humiliation. Without expecting any direct help, they still had to recount the litany of tragic events.

A number of cases came to the attention of the Task Force in which injured workers, while proceeding through rehabilitation programs, were cut off by the claims adjudicators from benefits without consultation with the rehabilitation counsellor or with the agency that was delivering rehabilitation services to the worker.

Such action might be traced back to the frustration felt by the WCB staff that the worker does not always display the motivation to return to work and seems to be costing the system a great deal of money. Such workers are called "malingerers" and, because of the overemphasis on the insurance aspects, tend to be rejected and denied service.

But many of these clients have invisible injuries, made worse by the length of time the condition has dragged on. They are people suffering from chronic emotional or physical problems that do not heal quickly. In fact, the Workers' Compensation Appeals Tribunal (WCAT) has recently recognized the legitimacy of chronic illness for compensation awards in Decision 915.

The WCB has no program for people suffering from invisible injuries. They are usually pensioned off according to a physical rating schedule sometimes referred to as a "meat chart", based on a fixed value for each part of the body, and receive a fraction of their previous income. They are then thrust into the community to live on welfare, family allowance, or income from other members of their family. This rejection of people who are not compliant and respectful of the system, people who may have psychogenic disabilities or are terrified of making a giant leap back into the workforce, illustrates the callous philosophy of the WCB today.

The board labels these people "malingerers" and convinces society, including the injured workers themselves, that the responsibility for the accident and difficulties encountered in rehabilitation rests mainly on them. By doing this, the WCB is demonstrating an attitude of inhumane disregard for the person and a rejection of industry's responsibility to workers hurt on the job.

The WCB merely shifts its financial burden onto other Ministries. In the long run, the cost in suffering and litigation, as well as in financial support, becomes greater than the cost of a sensitive service–delivery system.

The Task Force recognized that many of these so–called "malingerers" are people who are unable to return readily to competitive employment for many different reasons. If they were to be judged purely on a physical basis the judgement would invariably be harsh. They appear to be healthy and can perform leisure activities without apparent discomfort. Yet return to work is blocked. Complete disregard for the emotional impact of an industrial accident leads one to negate the problems these workers are facing. Return to work is a slow, laborious process and requires empathetic counselling.

The Task Force therefore recommends:

29. That the Minister of Labour initiate and coordinate efforts among the provincial and federal government to establish affirmative industries in all the major communities in Ontario to supply employment that would allow the gradual return of injured workers to competitive employment.

## *No Employment*

Despite the best efforts of the rehabilitation services, some workers may become so disabled that even segregated work is impossible. The Workers' Compensation and Rehabilitation Board must recognize its responsibility to these disabled workers and assure them of a program that will restore independence in the social and economic aspects of their lives.

The Task Force therefore recommends:

32. That the Workers' Compensation and Rehabilitation Board render such rehabilitation and compensation services as necessary to restore disabled workers to social and economic independence.

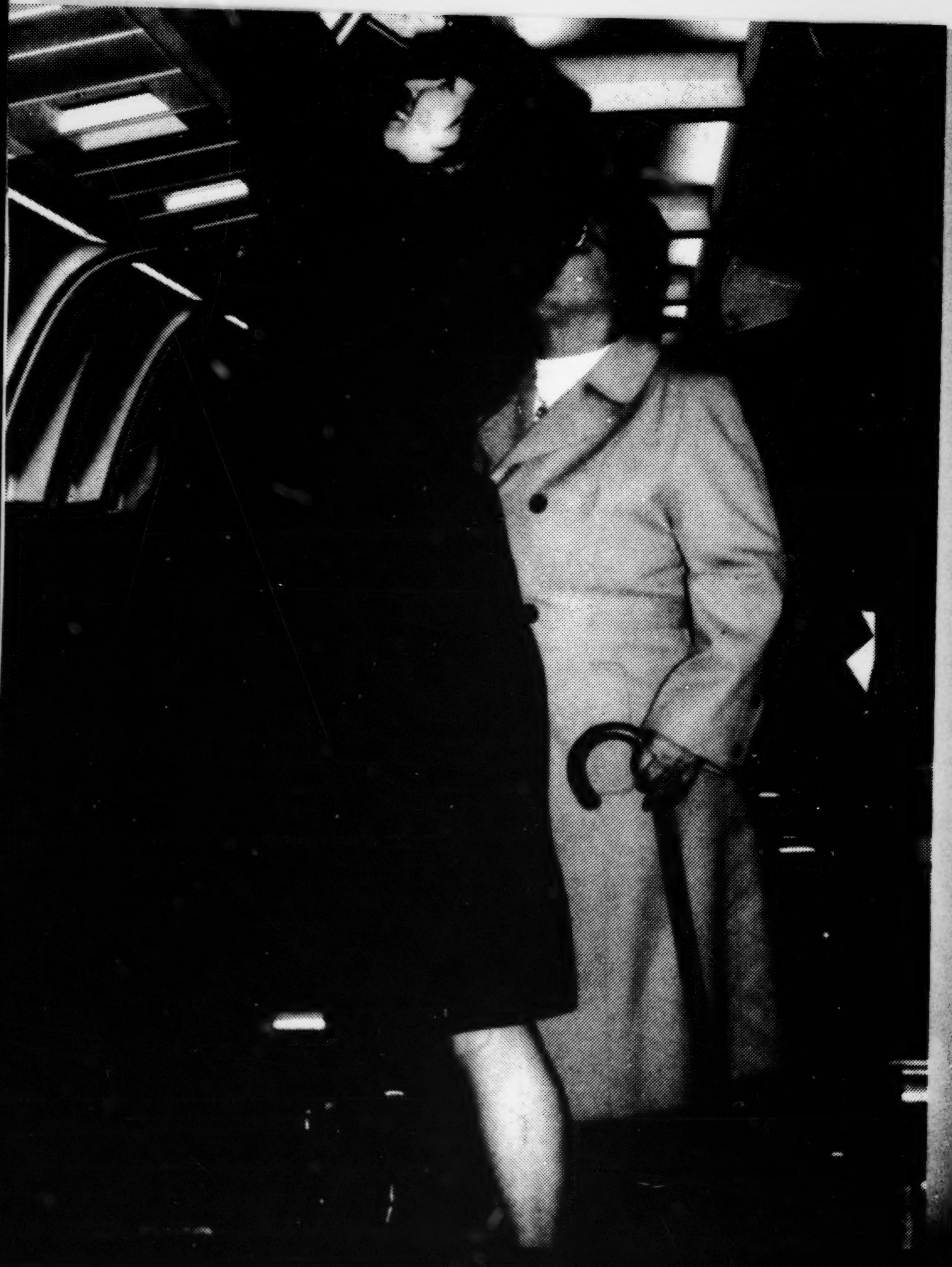
## *Appeals Procedure*

Regardless of the attempt by the Workers' Compensation and Rehabilitation Board to develop comprehensive and co–ordinated rehabilitation services for workers injured on the job and to involve the worker as an equal partner in the process, disputes will probably arise and an appeals procedure must be put into place. The Task Force abides by its principles of the centrality of the worker in the determination of any rehabilitation program and recommends:

33. That where the case manager is dissatisfied with a report from purchased rehabilitation services, the case manager must be able to purchase alternative services.

34. That where a worker contests a recommendation made by the case manager, the worker shall have the right of appeal to the case manager's supervisor. The worker shall have the right to request another case manager following a review by the supervisor.

35. That where the employer or injured worker is dissatisfied with the outcome of the recommendations reached by the case manager and the case manager's supervisor, they shall retain the right to appeal.



## Chapter 11

# Re–Employment

- *guidelines to re–employment*
- *the process of re–employment*
- *barriers to re–employment*
- *overcoming the barriers*
- *management and co–worker attitudes*
- *training*

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> *I asked her for assistance in preparing a resume — denied, she's overworked. I asked her to get my records from my educational transcripts — denied. I asked her for employment consulting; can I set up an appointment to see which areas, you know, I'd be suitable for — denied. She said, "WCB just doesn't have the funds for that."*
>
> Mr. Jim Cribben
> Injured Worker
> London, November 4, 1986

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> *...if a guy is going to give it a good shot to get back to work, and he re-hurts something, and he can get his compensation benefits, at least other guys are going to try to do the same. But the word out now is, hey, don't go back to work because if you do reinsure yourself, whatever part of your body, it's going to take you six months to get your first cheque. What it is is a disincentive.*
>
> Mr. Bob Perry
> General Manager, Dome Mines
> Timmins, October 22, 1986

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A set of guidelines was adopted by the Task Force relating to re-employment and is embedded within the principles of the Workers' Compensation and Rehabilitation Board. It serves as the basis for service delivery within the context of total rehabilitation as the right of all injured workers.

These guidelines are based on the centrality of the client. People who work at jobs and are seriously injured must be cared for and restored to their previous, pre-injury level of quality of life as much as possible. While re-employment is the preferred outcome of the rehabilitation process, restoration to the fullest possible extent in all areas of life is the fundamental goal.

## Guidelines to Re-Employment

There are six guidelines which underlie this re-employment process.

1. *The preferred re-employment outcome is always the one that most closely approximates the pre-injury job.*

Vash has suggested a way of looking at employment options for disabled workers and this model has been accepted by many organizations that deliver vocational rehabilitation services.

2. *Preference for re-employment options follows the Hierarchy of Employment Options.*

Level VI is a more preferable option than Level V, which is preferable to Level IV and so on.

3. *The worker is an equal partner in the development of any program of work reinstatement.*

Rehabilitation cannot be forced on people by threat. Individuals who recognize the benefits of the process are motivated to participate fully.

4. *The pre-injury employer should be consulted in formulating a vocational plan.*

Employers carry the burden of financial costs and would be responsible for reinstatement. They should therefore become part of the process and contribute their expertise.

5. *Rehabilitation services should be purchased in the community from non-profit and private service agencies.*

Rather than competing with rehabilitation programs that already exist in the community, the board should co-operate actively in ensuring that the services presently available are delivered effectively. Time, energy and money should not be wasted on the development of parallel systems. There is no reason to believe that services conducted by the WCB have been better than those performed elsewhere. In fact, the Downsview Review Team found evidence to show that work adjustment services were not being delivered at the Downsview Rehabilitation Centre there at all.

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*Again contracting out such services to the private sector or non-profit organization should be considered provided that private sector and non-profit organizations meet standards for consistency and adequacy of services as agreed upon by the industry.*

Canadian Manufacturing Association
Toronto, December 9, 1986

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6. *Human costs and suffering, loss of income, and quality of life supersede administrative costs.*

While there is no firm evidence to support this position, the Task Force feels that the amount of money being saved by denying rehabilitation services and benefits to injured workers is far less than that saved by offering them early, comprehensive and timely services.

## The Process of Re-Employment

Following the new guidelines, the process becomes clear and can be followed on a flow chart of service delivery. (See the flow chart on the following page).

In the flow chart, one can follow a case where the intake counsellor has determined that an injury is not serious, because both the worker and the employer have agreed that the worker can return to the previous job without problems.

In such a case, the employment resources worker needs to inform the injured worker that the job is waiting for him or her.

But it may happen that the worker cannot return to the same job, because it no longer exists for a variety of reasons. Yet, neither the worker nor the Acute Health Care physician have indicated that the injury is serious. At that point, the employment resources worker helps the worker find another position.

It may also be that the nature of the injury would dictate that it be termed serious under any of the following three conditions:

- because the Acute Health Care physician in the community has so determined,
- the worker is showing signs of a traumatic reaction to the injury, or
- placement is taking longer than 30 days.

Under these circumstances, referral to a case manager is made. Based on the Workers' Compensation and Rehabilitation Board guidelines, the case manager would determine the extent of injury in terms of the functional, emotional, social and vocational impact. The work of case management at this point is central and the quality of the person performing this task will shape the success of the outcome.

Following the referral, the case manager, together with the injured worker, begins to assess the extent of the injury and determines what the client needs.

## Barriers to Re-Employment

Barriers are blocks that limit or deny the opportunity for re-employment. They can be of two types: internal, that is, the workers themsleves, and external, the workers' environment.

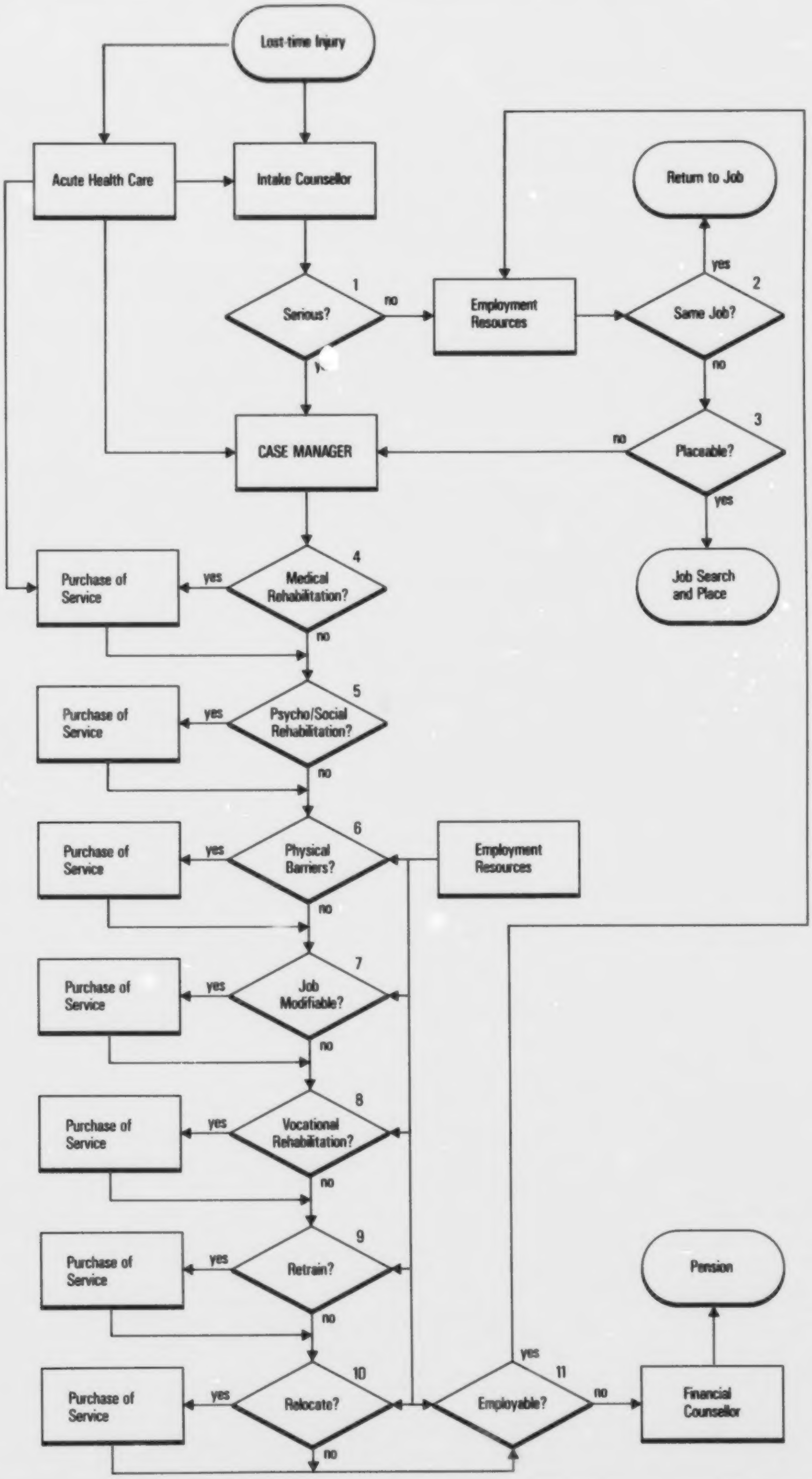
### Internal Barriers:

- age
- educational level
- type and extent of disability (functional limitations)
- type and extent of handicap (psychosocial limitations)

### External Barriers:

- lack of flexibility in the pre-injury job
- language barriers
- cultural barriers
- negative attitudes towards workers with disabilities
- the overall state of the economy and the general availability of job opportunities
- regional variations in unemployment and economic development

## Proposed Rehabilitation System


Lost-time Injury
Acute Health Care
Intake Counsellor
1
Serious?
no
yes
Employment Resources
2
Same Job?
yes
Return to Job
no
3
Placeable?
no
yes
Job Search and Place
CASE MANAGER
4
Medical Rehabilitation?
yes
Purchase of Service
no
5
Psycho/Social Rehabilitation?
yes
Purchase of Service
no
6
Physical Barriers?
yes
Purchase of Service
no
Employment Resources
7
Job Modifiable?
yes
Purchase of Service
no
8
Vocational Rehabilitation?
yes
Purchase of Service
no
9
Retrain?
yes
Purchase of Service
no
10
Relocate?
yes
Purchase of Service
no
11
Employable?
yes
no
Financial Counsellor
Pension

- instability in the labour market
- technological change and industrial transformation of the economy
- skill and knowledge requirements for future economic growth

Rehabilitation services that focus on disability tend to assess and develop programs geared to reducing or eliminating the effects of the injury on the client. They concentrate on the identification of the client's strengths and weaknesses. For example, age can be countered by experience and disability may be offset by strong motivation.

But gender, language and cultural barriers also exist for many of the workers because of the difficulties in accepting people, who are different as equal. They may be immigrants, or children of immigrants, Natives, agricultural workers or people who interact with society rarely because of location, religion or other cultural differences.

Nonetheless, these people deserve equal service delivered by those who are sensitive to the barriers they must face and interested in improving the conditions of the workplace.

Rehabilitation services that approach rehabilitation holistically and focus on handicaps must also be aware of the external barriers to re-employment. Barriers may exist because the community doesn't have enough jobs to ensure the re-employment of the injured worker. The type of job to which the worker is accustomed may have disappeared, not only in the community but in society at large. Or employment conditions may make re-employment at the same or similar job in the same community impossible.

What are the figures on the re-employment rate? In the statistics gathered by the Task Force in its study of 120 injured workers, the re-employment rate with the pre-injury employer was 24%. (This corresponds to the 21% figures available from the WCB.) The large majority of injured workers therefore have no alternative but to seek work elsewhere, often without the help of the board except for the threat of losing benefits within a fixed time limit if no job is found.

The statistics for client closures in 1986 shows that 41% of clients (4,156) were closed in the category of *No Further Rehabilitation Action Indicated* (NFRAI). But what does this category mean?

It means that all three outcomes are possible:

- they remain unemployed
- 80 to 90% lose some or all of their benefits
- they are terminated from the Vocational Rehabilitation Division and benefits are either reduced by 50% or totally suspended. Injured workers have the right to appeal this decision if they wish, but this usually means a lengthy wait if they have to go before hearings officers and a further delay if their claims go to WCAT. During this period the workers must live on either their pensions or social welfare.

Based on this analysis, about 4,000 to 4,500 injured workers are relegated to informal and formal income support systems each year as a result of the VRD's inability to place them in jobs. The Vocational Rehabilitation Division conducts no follow-up of these cases to determine how these unplaced clients will support themselves, though many will re-enter the WCB system through additional claims or appeals.

Statistical data gathered by Task Force researchers suggest that young, well-educated, married and higher income clients with stabilized medical conditions have a better chance of overcoming employment barriers. In contrast, poor and/or ethnic workers with chronic or degenerative conditions have a poorer work prognosis. They are the ones who are cut from the rosters for "NFRAI" reasons.

Yet these are the people who are most vulnerable and need the greatest amount of assistance. These are the people for whom external barriers are greatest. And these are the ones for whom there is least empathy and understanding.

**VOCATIONAL REHABILITATION SERVICES**
**1986 CLIENT CLOSURES**

| Closure category | N | % |
|---|---|---|
| REHABILITATED | | |
| New Employer | 2,678 | 26.5 |
| Accident Employer | 2,145 | 21.2 |
| Self Employed | 328 | 3.3 |
| SUB-TOTAL EMPLOYED | 5,151 | 51.0 |
| Financially Self-Sufficient | 794 | 7.9 |
| SUB-TOTAL REHABILITATED | 5,945 | 58.9 |
| *No further Rehabilitation Action Indicated (NFRAI)*<br>*(For definitions of categories, see Appendix)* | | |
| Not prepared to leave Accident Employer | 43 | 0.4 |
| Self-Imposed Restrictions | | |
| -Compensable | 1,197 | 19.0 |
| -Non-Compensable | 298 | 3.0 |
| -Employment Related | 142 | 1.4 |
| No Response | 164 | 1.6 |
| Returned to School | 36 | 0.4 |
| Geographic Conditions | 112 | 1.1 |
| Full Recovery | 735 | 7.3 |
| Unco-operative | 143 | 1.4 |
| Deceased | | 0.3 |
| Withdrawn | 534 | 5.3 |
| SUB-TOTAL NFRAI | 4,156 | 641.1 |
| TOTAL SERVICES COMPLETED | 10,101 | 100.00 |

*(Source: Vocational Rehabilitation Services Division, Ontario Workers' Compensation Board)*

## *Overcoming the Barriers*

In an ideal system employers would be responsible for all workers injured at the workplace and return them to their pre-injury job, modified work or an alternate position. To this end, the Task Force has recommended that reinstatement be mandatory.

But in reality there are factors that make it difficult for reinstatement to occur.

- the company or organization no longer exists
- the injured worker does not wish to return to the pre-injury employer
- antagonism and prejudice at the pre-injury job by management or fellow workers may make retention of the job impossible

Under these conditions the WCB must be pro-active in reducing such barriers. The mission of the board must direct it to intervene in changing negative attitudes towards, and misperceptions of, injured workers.

Total rehabilitation is essentially the removal of internal and external barriers which are identified in the assessment process. By removing or overcoming them to the greatest possible extent, the individual is left as independent in all aspects of life as possible.

The Workers' Compensation and Rehabilitation Board is concerned mainly with the removal or reduction of those barriers that restrict the individual from performing a job. But it is clear that successful vocational performance is based on the ability to perform in the physical, social and emotional areas of life as well. Successful rehabilitation cannot ignore all these other aspects as if they were of lesser importance, because they can disrupt successful work performance, reduce efficiency, increase absenteeism and disrupt a harmonious work environment.

Therefore the process of rehabilitation begins with assessment but continues with intervention in all the areas where weaknesses or barriers are identified, in the individual and the society in which he or she lives and works. It is of interest to note that life insurance companies in Ontario have recently become aware that investment in rehabilitation will yield financial benefits in reduced compensation and also in satisfied customers.

## *Management Attitudes*

There are a number of misconceptions about injured workers among employers: "Hiring an injured worker only means trouble for my company." "My insurance rates will skyrocket."

"They need a lot of expensive worksite modifications." "Their safety records are poor." "Productivity will go downhill." "None of my other employees will accept them."

In fact, none of these statements is true. Earlier and more successful re-employment rates can actually decrease assessment rates. Worksite modifications are usually very inexpensive and if appropriate physical and social changes occur, safety records remain the same or actually improve. Several North American studies show that the productivity of injured employees is actually quite high and whether employees accept the disabled or not really depends on how management sees them.

So the rational reasons managers give for not hiring the disabled really have no basis in fact. Emotional objections are a little more difficult to address. For example, employers frequently feel that the "invisibly disabled" — back-injured workers, in particular are malingerers. In fact, according to one study of 2,500 industrially-injured workers, only seven were found to be fraudulent.

Worse, there seems to be a common North American attitude, that people with disabilities somehow deserve them through their bad, inattentive or lazy behaviour. Moreover, some employers and co-workers simply don't know how to treat or react to an injured person.

Changing negative management attitudes requires extensive appropriate communications, education and training to specific results-oriented, behavioral modifications.

Positive management attitudes can lead to tolerant management practices toward people with limitations, significantly improving injured worker success and decreasing risk of further disablement. For example, a study of workers with rheumatoid arthritis found that when workers controlled their hours and the pace and output of their work, the probability that they would become further disabled was greatly reduced. When their superiors set the pace of work, disablement increased significantly.

Any special measures taken to socially integrate injured employees are more successful if dovetailed with general personnel policies and practices that ban discrimination and encourage equal treatment of all minority groups. For a group with physical limitations, the availability of sick time and health benefits, fair promotion practices and employment equity programs all encourage social acceptance of employees with disabilities.

Viewing injured co-workers as "injured athletes" also helps reinforce the returning worker's status as an important member of the team. One large Toronto employer encourages this attitude by placing recovering workers in lead hand positions. As former Minister of Manpower and Immigration Minister Bud Cullen said 11 years ago:

> *You may say that there are physical barriers in your plant which prevent you from hiring handicapped people. Are you sure? True, some barriers exist, but some have simple solutions perhaps a desk needs to be raised or lowered, perhaps a simple rearrangement of the way duties are divided between two workers is all that is needed. Are the barriers absolutely insurmountable?*
>
> *I believe there are many ways in which we can all combine our various roles to assist you to find productive, committed people who have handicaps. It is, after all, the skills and the experience of the individual that matter, not the handicap.*

Therefore the Task Force recommends:

24. That the Workers' Compensation and Rehabilitation Board take a proactive role in working with the community to reduce environmental barriers to the employment of people with physical or emotional injuries.

## *Training*

Major changes in the structure of the economy, such as the shift from manufacturing to service jobs and the increased use of advanced technology in production, require a more educated work force. In this changing economy, unskilled, uneducated and older workers will have the most difficult time finding new jobs. Those that are disabled will find it harder still.

The demand for an increasingly sophisticated work force means any training provided should integrate basic skills-upgrading with any form of vocational rehabilitation offered. For many workers training-on-the-job is the most appropriate form of rehabilitation and should be more effectively used, especially in conjunction with other forms of upgrading, and as an entry to a permanent job in the labour market.

However, for those injured workers who have not been placed through the rehabilitation services and must anticipate a job search in today's labour market, formal training is likely to enhance one's chances of finding meaningful work.

The training programs which are used by the Vocational Rehabilitation Division range considerably in their target groups and goals. They include English as a Second Language, training-on-the-job, and formal training programs for technical upgrading, educational upgrading, business training and post-secondary education.

Despite a rapid and continuous rise in the number of workers referred to Vocational Rehabilitation Division over the past five years, the proportion of individuals who commenced training programs in this period has failed to keep pace. In fact, there has been a steady decrease in the proportion of workers who have gained access to training, from 39.4% of referrals in 1980 to 23.2% in 1985. Thus, only about one-quarter of the injured workers who are deemed eligible for rehabilitation services will get an opportunity to prepare themselves in some way for a relatively hostile labour market.

Training expenditures have also decreased, both in terms of the percentage of Section 54 expenditures allocated to training and in actual dollars spent on training, from approximately $2.1 million in 1983 to $1.9 million in 1985. Furthermore, for every dollar the Board spent directly on rehabilitated workers in 1985, it spent more than $3 dollars on the administrative system to deliver this service. Clearly, spending priorities need to be realigned.

Therefore the Task Force recommends:

25. That the trend of decreasing expenditures for training be reversed to reflect the value of training as a rehabilitation tool for injured workers.

Vocational rehabilitation must not be tied to the degree of disability but to the level of skills required to get a new job. For example, by far the largest majority of claims involved back disabilities.

Most pensions for injured workers with back disabilities fall between 10% and 20%, although they are unprepared in terms of their marketable skills to find work which they can perform with this degree of disability. Vocational rehabilitation service might be limited to counselling for job search; whereas what is really needed is retraining or skill upgrading to get access to the type of work which will not make this condition worse.

ESL must be needs and goals based. To say that ESL is available throughout the community at no cost is to avoid the issue that injured workers have a very specific set of needs and goals in trying to upgrade their command of English.

ESL would be more effective if offered in conjunction with whatever form of training is being provided the injured worker. It should reinforce what is being taught in the program, covering such topics as job search in the job, tools, techniques and terminology common to the occupational area. Verbal communication should be stressed over written work such as grammar and spelling.

Formal training in university and community college programs must be viable options. Any program which is offered injured workers, especially ESL and vocational training, should be based on their particular requirements.

If a worker has gone through upgrading before the accident he should have the right to continue to do so after. If he is entitled to rehabilitation services and wishes to upgrade to a Grade 12 level of education along with vocational retraining, this should also be a right.

Completion of upgrading programs such as ESL should not limit access to further training programs. All injured workers should have a right to formal academic or technical training if this is established as the best route to successful rehabilitation in their individual situation.

## Chapter 12

# Job Modification

- *modifying the job or workplace*
- *WCB guidelines*
- *some problems*
- *ergonomics, an important tool*

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*I was out for about seven or eight weeks after the motor fell on me. I went back to work with pain. There was no doubt I was having trouble. I went back on my job and my hands started going on me from running those air guns. I would go home at night and soak them in hot water. I was taking pain killers by the bottles. When I went back to the foreman and said to take me off this job, I said, "I can't handle the air guns anymore. My hands are giving me too much trouble." And he told me out and out, "If you can't do the job, I'll get somebody that will." And all I had to do was...move down on the next operation and put parts in boxes.*

Mr. Jack Drummond
Injured Worker
Peterborough, November 19, 1986

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*Our committee has, for some time, been deeply concerned with the lack of adequate vocational rehabilitation assistance to injured workers in the railway industry, which has, in many instances, forced some workers to seek medical disability pensions or early retirement due to railway employers not providing modified work when the injured worker is incapable of their pre-accident employment.*

Mr. Carl W. Carew
Ontario Legislative Committee of
Canadian Railway Labourers' Association
Toronto, December 9, 1986

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According to the WCB's 1985 annual report, 103,130 workers received pensions for some degree of permanent disability in that year. In 1981, the WCB found that 40% of (non-active cases) injured workers were unemployed. Of this group, 70% had pensions assessed at less than 20%.

These figures suggest that most of these people are not totally unemployable. Their pensions certainly provide no financial incentives to remain unemployed. Evidently, not enough is being done to maximize the potential contribution injured workers can make to our economy and their own lives.

Workplace modification expenditures should be viewed by both the WCB and the employer as "investments" that can save considerable financial resources in the long run and provide real help to injured workers as well as provide considerable prevention of future disabilities.

However, one of the most underutilized programs of the WCB is that of job modification. Spending in this area in 1985 was only $56,013 and although it reached a peak of $101,938 in 1986 it is still a very small part of the $17 million Vocational Rehabilitation Division budget. Yet job modification has the potential of returning a large number of injured workers to the workforce where they can earn a living instead of just getting by on a small pension.

## Modifying the Job or Workplace

Job or work modification refers to a variety of changes in the workplace carried out to enhance a disabled worker's ability to do a satisfactory job.

Physical changes to the workplace itself, or worksite modification, requires an assessment and matching of the needs of the injured worker with the physical layout, machinery and/or materials of the worksite.

Job modification for an injured worker is considerably easier if the employer has already completed a physical demands analysis for all positions within the firm. A physical demands analysis permits employers to determine the specific physical requirements of a job.

This includes the necessary strength, mobility and sensory/perceptual abilities, as well as the normal work conditions, hazards and environment encountered by those in the job. The physical demands analysis checklist becomes part of the position description, used to determine general compensation and appropriate modifications for the injured worker.

The Employers Council for the Disabled of the Personnel Association of Toronto listed a variety of potential methods of modifying jobs and/workplaces. They included:

1. Designing more flexible worksite layouts, such as:
   - adjustable files or shelves that are accessible to those in wheelchairs
   - widening areas between fixtures to allow room for persons with mobility impairments (i.e. wheelchairs, leg braces, canes)
   - raising or lowering equipment to provide comfortable working heights
2. Rescheduling work hours to accommodate persons with limited stamina or psychological or emotional disabilities.
3. Reassigning non–essential job duties to a co–worker, or restructuring a job to eliminate stress or physical discomfort.
4. Acquiring technical aids or adapting equipment, such as:
   - placing braille labels or tactile cues on shelves so that blind employees can identify the contents
   - redesigning the layout of equipment controls or modifying them for hand or foot operation
   - installing special holding devices on desks, machines or benches
   - providing speaker phones or extension arms to hold telephone receivers
   - installing telecommunication devices or telephone amplifiers for persons who are hearing impaired.

Job modification is not only an excellent way of providing work for an injured worker but also potentially a boon to the employer who can gain immensely from the return of a skilled, experienced worker to the job site.

There are some employers who invest large sums of money on jobsite modifications to keep valued workers. On the other hand, possibly because of the stigma attached to the injured worker, some employers may be reluctant to return an injured worker to the job. Many are also unaware that the WCB has a program to help employers both financially and with their expertise in job modification.

## *WCB Guidelines*

The WCB has set out several guidelines for modified job programs.

1. They assist in a return to work as soon as possible after the injury.
2. There is continuous employer contact with the worker after the accident.
3. A joint management/labour committee, wherever possible, reviews each injured worker's situation on a regular basis.
4. Suitable (or modified) positions are identified and agreed to by both union and management to ensure that the new position protects the worker from the possibility of aggravating his/her condition and that such placement does not endanger fellow workers.
5. Vocational rehabilitation staff is consulted, where appropriate, in reviewing and selecting positions, from an ergonomic standpoint, to ensure that the employee can complete the tasks involved or that the tasks are arranged to suit the employee. WCB sponsored assessments and training–on–the–job sessions are well utilized.
6. Part–time positions are available for those unable to manage a complete shift.
7. Medical support is obtained to ensure the worker's ability to perform the required duties.
8. Opportunities are provided for general physical conditioning of workers who have been absent from heavy labouring positions for a prolonged period to allow gradual reintroduction to full activity.

Of the programs identified by Task Force research, the majority were employer–driven in that the WCB reacted in response to employers' inquiries about the service. The Task Force was made informally aware that most of these employers were motivated by threat of increased assessment.

The key to selling the program is indicating to the accident employer that the injured worker can be tried out at no wage cost. However, Section 54 expenditures are advertised mostly as maintenance allowance tools for the employer, not workplace modifications.

## *Some Problems*

Job modification programs are designed to allow the injured worker to re-enter the work force as quickly as possible. The reasons for this are apparent. The financial incentive of lower costs through lower lost-time accidents encourage such programs. Reduced costs can be achieved by cutting down on the number of accidents or bringing the injured worker back sooner.

Based on an examination of five existing job modification programs, the Task Force reached the following conclusions:

1. The incentive of reduced costs appears to be effective. On the other hand, some companies do only the minimum.
2. There has been little use of worksite modification or task reallocation to create and apply these plans. Ergonomic principles and resources also appear to be underutilized.
3. Job modification programs are geared to those injured workers who are the easiest to reintegrate into the workforce. Little or nothing is done for the difficult cases.
4. Economic conditions have also played a role. Whereas companies find it relatively easy to accommodate injured workers during times of prosperity, their flexibility during tight economic conditions is limited.

## *Ergonomics, An Important Tool*

If job modification were taken seriously, then the role of the ergonomist would be extremely important in the rehabilitation process of injured workers, both with accident and new employers. An ergonomically sound examination of the work process provides a dynamic link between health and safety and accessibility, addressing both the issues raised by the reintegration of an injured worker and prevention of similar disabilities. To make this option more effective more employers should be made aware that Section 54 funds are available.

However, it is important that ergonomic analysis not be used with time and motion studies to maximize productivity, in order to shoe-horn an injured worker into a job defined by the employer or the WCB as suitable. In this context, the bottom line on job suitability must be the injured workers' own "ergonomic" assessment of what a particular job, or part of the work process, would require of their abilities.

The WCB states that it will provide, on request, a worksite analysis team whose members are made up of kinesiologists, physiatrists, adaptive physiologists and ergonomics specialists. Individuals go into the workplace directly to study the actual conditions, then come back and consult with other team members. Often they will liaise with company engineers to find solutions to specific job modification problems. However, as one employer noted, it can take months for these services to be made available.

At the time of this report, there were only three ergonomics specialists on staff at the WCB. For the most part, their services are used in job modification programs if 1) the company sees a higher risk of or actual accident rate or, 2) when there is an adjudication issue regarding a discrepancy about whether or not an injured worker can perform the recommended job. In both these instances it is the worksite or tasks, and not measures associated with the injured worker's performance of the job, which are generally assessed.

Unfortunately, the requirements for professional expertise are somewhat questionable since courses in ergonomics are unnecessary to get hired. Furthermore, the ergonomists interviewed by the Task Force reported that 80% of their time was spent on paperwork, leaving a mere 20% on the worksite, travelling, with the injured worker or talking to the employer.

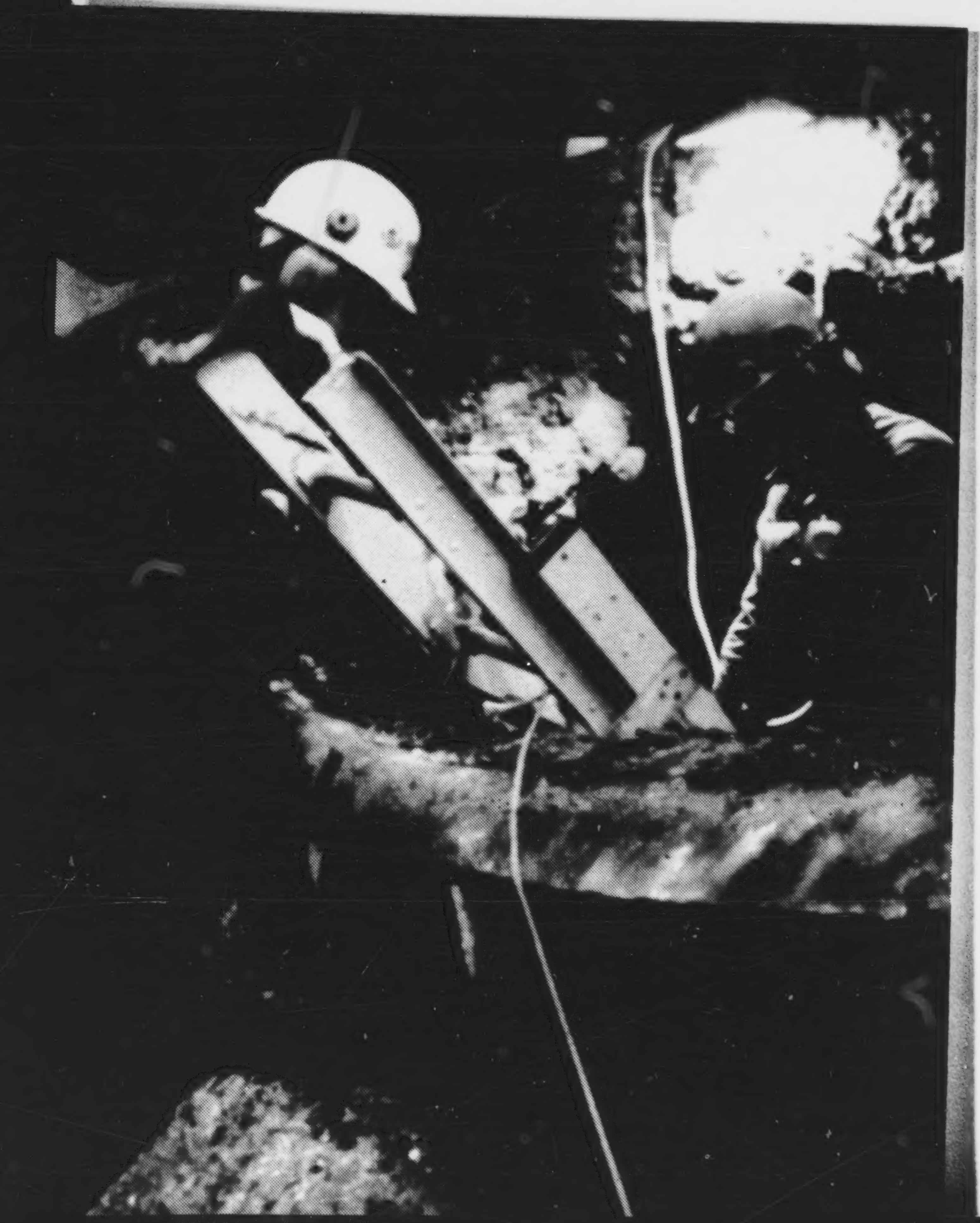
Job modification is potentially an excellent method of returning injured workers to productivity. However, unless stricter hiring standards for ergonomists are introduced and the availability of such programs is more widely recognized, its full potential will not be fully realized by employers.

The Task Force therefore recommends:

36. That the Workers' Compensation and Rehabilitation Board take a pro–active role in promoting job modification practice in Ontario by increasing the number of trained ergonomists on staff and making use of trained personnel in the community.

37. That the Workers' Compensation and Rehabilitation Board advertise its availability to assist businesses with expert advice and financial incentives in the development of job modification programs.

38. That personnel hired by Workers' Compensation and Rehabilitation Board in the capacity of ergonomists shall have appropriate training in ergonomic planning and assessment.



## Chapter 13

# Communications

- *injured workers*
- *employers*
- *staff*
- *communications arm essential*
- *the need for research*

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> *I ended up going to the swimming pool, and I didn't think I should have been there, because the cut was still open, and I mentioned it to the therapist, Carl, and he told me, he says, "You're nothing but a faker..."*
>
> Tom Bates
> Injured Worker
> Windsor, November 6, 1986

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> *In my current role at the Peterborough plant location, I guess I've been there about three years and dealt with some of my predecessors with this question as well, and no one has ever met a representative of the Board regarding rehabilitation services. I think that something like that would really serve our function so well, if we had a name, someone we could deal with, someone at the end of a phone who could tell us what sort of things are happening within the Board, services within the community that are being utilized for rehabilitation or possibly be used in rehabilitation cases, etc. We would like to see someone come to our facility and help us out.*
>
> Mr. Dean Mackay
> Safety Office, Quaker Oats
> Peterborough, November 19, 1986

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In the course of its investigations the Task Force repeatedly heard complaints from all segments of the population that communications with the WCB was extremely difficult.

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> *The lack of good, open communication has contributed to a lack of trust and to confusion between the WCB, the employee and the employer. This has created the present adversary system in lieu of the more desirable co-operative system. It also gives the illusion that the WCB appears to have overlooked the reason for its existence in the area of rehabilitation.*
>
> Timmins Chamber of Commerce
> Timmins, October 17, 1986

❑ ❑ ❑

The transfer of information is a vital function of any organization. Data must be transmitted and received within and between the board and its various publics. Communications must be two-directional, that is, listening as well as telling. The WCB must also ensure that any messages it transmits take the language and cultural restrictions of the receiver into account.

Internally, the development of Integrated Service Units (ISUs), which gather people from different disciplines in one location with job functions that require communications, may prove to be beneficial. But it is also necessary to change the working relationships among the ISU members to clarify the communication requirements. The model of the ISU seems to require the transmission of all data to a supervisor for distribution to the rest of the unit members. Earlier in this report, the Task Force argued the need for a case management approach, which would require the case manager to seek information directly from other staff members as well as to keep them informed about decisions being made.

## *Injured Workers*

The major complaints came from injured workers, especially those who didn't speak English. They complained about the difficulty in understanding what was expected of them and the troubles they encountered trying to tell the WCB their problems. Again and again, Italian, Greek and Portuguese workers would relate their problems in overcoming language and cultural barriers that militated against an understanding of each other's point of view.

Injured workers complain strongly about two things: that they are misunderstood and they have no one to turn to in time of need. In one case that came to the attention of the Task Force, a Greek-speaking worker reported that he came to the Psychology Department dressed up in his one special suit, only to be told that he must be financially comfortable because the suit must have cost more than that of the psychologist. All communications were through the worker's wife. The staff member misunderstood what was said, became hostile and accused the client of malingering.

According to a study of injured workers commissioned by the Task Force, 51.7% do not speak English as their first language and come from a different culture. Over 30% had less than a grade eight education.

Even when a worker's ability to speak English is fairly good, the next big hurdle is taking on the intricacies of the WCB bureaucratic machine. Correspondence from the board is confusing to even the best-educated reader and incomprehensible to the poorly schooled, older, non-English speaker. Rights are not clearly defined, making the system seem arbitrary and unnecessarily bogged down in red tape. Workers who receive assessments at the instigation of the Vocational Rehabilitation Division don't understand why they've been given the tests and rarely see the results.

Counsellors must be able to transcend cultural and language barriers before they undertake case management. They must undergo intensive courses in counselling techniques of the disabled and individuals with different cultures.

The Task Force therefore recommends:

9. That staff of the rehabilitation division be required to take training in counselling people with disabilities and people who are culturally diverse.

The Workers' Compensation and Rehabilitation Board will take a pro-active role in contacting injured workers as soon as possible after the accident, making sure they understand their rights and obligations. To ensure there is always someone there who thoroughly understands the circumstances of each injured worker, a case management system will be implemented. This is discussed further in the section on case management.

* * *

*Information provided by the communications department of the Board is not trusted by the injured workers as it is perceived to reflect the interests of the Board and not the interests of the workers.*

*Injured workers are poorly informed of their rights.*

*Written informational materials for injured workers provided by the Board should be at a level easily understood by the lay person.*

Portuguese Interagency Network
Toronto, January 23, 1987

* * *

## Employers

The employers also had problems with understanding or identifying the sources of the pronouncements that came from the WCB — whether general statements about procedures or decisions in specific cases.

Employer concerns with communication centre on the lack of information they receive from the Rehabilitation Division regarding the roles they must play in case of an accident, and in their inability to identify responsible staff when needed.

* * *

*Following an incomplete recovery from an injury, the WCB typically relays the worker's work restrictions to the employer by means of the form "Progress Note to Employer" or follow-up letter. These restrictions are extremely brief and vague in nature, to the degree that they provide little guidance in identifying appropriate work at which the worker is likely to succeed and/or is not likely to re-aggravate the injury. For example, one such restriction note read as follows: "No bending or lifting. No prolonged standing, sitting or walking."*

The Corporation of the City of Hamilton
Hamilton, November 20, 1986

* * *

The Task Force therefore assigns the task of keeping employers informed about rehabilitation services to the director of communications in the division and requires that procedures be organized so that continued communications with employers are maintained on a bi-directional basis.

At the same time the Task Force recognizes that the front line staff of the division would be the ones to keep lines of communication open.

* * *

> *Central communication person — one case manager would facilitate communication between the injured worker, employer and the various professionals and would in all likelihood result in better service delivery.*
>
> Orthopaedic and Arthritic Hospital
> Toronto, December, 1986

* * *

The Task Force therefore recommends:

10. That the case manager's job requires the manager to take time to go to conferences, workshops, field trips and visits to job sites, so that two-way communication avenues be kept open.

* * *

> *We don't feel employers have a role to play in terms of vocational evaluation services. It is a sophisticated process to determine the capabilities of injured workers — most employers don't have the expertise to contribute here. It should be left with the Workers' Compensation Board. However, we do feel the Board should be advising the employer of the findings when an injured worker has been assessed. Now all we receive is an invoice for a disability pension and a temporary supplementary payment with no explanation of what has happened to the worker.*
>
> City of Sarnia
> Sarnia, October 28, 1986

* * *

## *Staff*

Finally, the counselling staff complained about the lack of communications within the organization and with agencies and employers. They felt that decisions were being made about their clients by personnel in the claims division without sharing information. They argued that agencies were not giving them feedback when it was needed and of the type that was required.

Internal communications would help reduce the tensions the staff complains about, tensions that seem to be caused by rumours constantly flying about. Many members of the Vocational Rehabilitation staff are on the road and come into the office once a week. There they pick up informal gossip and have no way of separating rumours from directives. The staff also require meetings to share professional information that would help them grow as counsellors.

* * *

> *Sharing of appropriate client information and client background with service providers in order that they may better understand the history and needs of the injured workers. The present system of total secrecy of files suggests mistrust and delays placement in appropriate vocational rehabilitation programs and employment.*
>
> Ontario March of Dimes
> Toronto, December 11, 1986

* * *

The Task Force therefore recommends:

6. That formal meetings of rehabilitation staff be held at least once a month for the staff to discuss policy and official directives and, in turn, to inform management about their experiences, opinions and attitudes and can discuss difficult or interesting cases.

8. That the Director of Rehabilitation Communications establish and maintain a quarterly newsletter for the rehabilitation staff that would inform as well as solicit information and opinion.

All in all, the Task Force found that communications in the WCB, and especially in the Vocational Rehabilitation Division, was an example of the worst features of a large, overstructured organization. Communications were generally through official memos and almost invariably were directed externally — telling but not listening.

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> *The WCB is not well understood. It is seen as a difficult agency to deal with most times. None of the physicians have been formally briefed on the WCB system, its expectations, requirements and branches. The relationship between medical services, claims and vocational rehabilitation is not known to physicians.*

Dr. Douglas G. Morrison,
Algoma Steel Corporation
Sault St. Marie, October 14, 1986

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## Communications Arm Essential

The Vocational Rehabilitation Division does not appear to have its own communications system and so must rely on general WCB communications to inform the public of its activities. But this fails to fulfil an important function. It does not clarify to employers or to injured workers the activities of rehabilitation as separate from claims activities. To the public, therefore, the two merge so that the Task Force and the research team found that injured workers, especially those with language and cultural barriers, voiced general complaints about the whole system, and failed to recognize the distinctions among its divisions.

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> *The delay in communication between vocational rehabilitation counsellors and employers is serious, as it reinforces the illness cycle by promoting continued disassociation of the injured worker from the workplace. Time lags of four weeks and more have been recorded prior to the implementation of work return programming. This poor response time is viewed as unproductive, costly and unnecessary.*

Chedoke–McMaster Hospitals
Hamilton, December 1, 1986

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Therefore the Task Force recommends:

7. That the rehabilitation division establish its own communications arm, which will serve to inform, transmit opinion, receive plaudits and complaints, and recommend improvements in service delivery.

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> *Good, open communications must be established between the employer, regional Vocational Rehabilitation Services counsellors and local treating agencies with regard to a mutual understanding of the injured worker's scope of work and workplace environment.*

Ontario Chamber of Commerce
Toronto, January 23, 1987

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## The Need for Research

There is a tendency in some organizations to restrict communications to informing the public of its activities, in effect, publicizing itself. This may lead to a situation where the organization talks to others but doesn't listen, unless it is forced to do so. The WCB seems to have evolved this way.

If any program evaluations have been conducted, needs assessments or outcome measures studies performed, the results must have not been made public. There are few internal staff who are able to conduct such research, and rarely has the WCB invited such studies externally. In fact, when outside researchers have requested permission to conduct studies of board clients, they have been refused permission. This promotes the appearance of the WCB as a closed, secretive organization.

Yet with close to half a million claims made each year the WCB could become an important source of knowledge about rehabilitation procedures and helping people who have accidents.

Two kinds of research could and should be conducted — applied research that will help to improve the effectiveness of service delivery of the WCB and basic research that will inform rehabilitation practitioners of the nature and consequences of work–related injuries and diseases. Such research would improve rehabilitation services both within the board and within the field in general.

The Task Force therefore recommends:

11. That the Workers' Compensation and Rehabilitation Board establish a program evaluation system to track the effectiveness of its rehabilitation services and to conduct follow–up studies.

12. That the Workers' Compensation and Rehabilitation Board establish a research fund to finance internal and external research into basic and applied issues that deal with conditions of disablement, occupational health and safety, outcome research and other areas of interest to rehabilitation of injured workers.

## Chapter 14

# The Need for Regionalization

- *integrated service units*
- *medical rehabilitation*
- *Northern Ontario*
- *Northern study*
- *existing services in Northern Ontario*
- *transportation linkages*
- *establishment of rehabilitation facilities*
- *pertinent maps and tables*

* * *

> *...my flight home was delayed till the following morning due to the bad weather. I called the Rehab Centre, explaining myself, and asked them to pick me back up as I had no money for a room or a taxi back to the Rehab Centre. The Rehab's answer was, "Sorry, everybody left for the weekend and we are closed."...I tried to get some rest sitting in a chair but I couldn't because my back and leg pains were out of control. I also was unable to eat, but I had a cup of coffee that night because I was broke. The Workers' Compensation Board also did not pay my taxi fare...I had to hitchhike home from the Elliot Lake Airport in the wintertime.*
>
> Mr. Horst Schimiczer
> Injured Worker
> Elliot Lake, October 22, 1986

* * *

> *It is the private non-profit organizations that have the counselling skills and expertise to deal with the emotional aspects of the injured worker. Their services should be utilized by WCB. In addition, using community services would decrease the negative attitude clients feel when dealing with the bureaucratic system of WCB.*
>
> Mr. Bernie Berger
> Executive Director
> Jewish Vocational Services
> Toronto, December 9, 1986

* * *

The Task Force adheres to the principle that rehabilitation services should be delivered as close to the worker's home as possible. Downsview Rehabilitation Centre is a clear example of how things can go wrong when workers are uprooted from their homes and sent to a strange centre, far away from their culture and community and forced to live in premises that invite harassment and disregard for the individuality of the person.

The Task Force recommended strongly in December 1986 that Downsview Rehabilitation Centre cease operations as a medical and vocational rehabilitation centre. In response to the public insistence of the Task Force, the Minister of Labour then established a review team, which examined the conditions under which injured workers were sent to Downsview Rehabilitation Centre and the services they received there.

The final report of the review team was clear and definite. It reflected similar concerns to those of the Task Force and reached identical conclusions.

Downsview Rehabilitation Centre was clearly not discharging its responsibilities effectively. It was ignoring suitable vocational rehabilitation, offering only a form of medical and functional assessment. It was neglecting the needs of injured workers and was the focus of great discontent among the many injured workers and employers who were referred there.

A comprehensive audit of the Downsview Rehabilitation Centre in April 1987, conducted by Deloitte Haskins & Sells, identified similar problems. It wrote:

> *The operating focus of the program administration has evolved ensuring that patients attend the determined program of treatment. The objective of the program to provide treatment to patients may have shifted to that of ensuring that patients are fully occupied while they are at the DRC. In turn, program operating procedures may have become oriented toward patient control rather than patient assistance.*

and again:

> *Observation: the DRC organization and resource base is not positioned to return injured workers to their regular work or to arrange modified or different employment. The DRC is structured to provide medical and paramedical rehabilitation assessment and treatment. Further responsibilities are outside the scope of the DRC and can, at best, be provided by a service which operates and controls counsellors located centrally and in the field.*

The Task Force therefore recommends:

65. That the Minister of Labour adopt all the recommendations of the Downsview Rehabilitation Centre Review Team, including those concerned with the cessation of vocational assessments at Downsview Rehabilitation Centre.

## Integrated Service Units

Recently, the WCB has proposed the establishment of Integrated Service Units (ISUs) to achieve "the board's ability to deliver client services in a more personalized but still cost effective way". The WCB proposes that these ISUs "will allow for a co-ordinated and consistent approach to programme delivery."

But this cosmetic change in service delivery, though appearing to be creative and innovative, is nothing more than a new alignment of desks. It fails to address the important issues.

The WCB might argue that, in an ISU, earlier intervention will be promoted. But the organizational chart of a unit shows that a supervisor, who may not be a rehabilitation counsellor, will head each team of nine or ten service delivery personnel, only two or three of whom will be members of the rehabilitation team. Since criteria for referral to rehabilitation are not being redesigned, early intervention decisions will still be made by the same claims adjudicators, on the same basis and with similar claims-driven goals. The only reason for proposing ISUs seems to be, not to improve the quality of rehabilitation services to the injured worker, but to save money. This is obvious because the WCB's definition of rehabilitation, and the acknowledgement of the importance of reducing all effects of a person's disablement, have not changed.

There is no reason to believe that setting up an ISU will increase consistency. Providing greater opportunity for communications among the staff may be more helpful to management than the client. The team approach is useful when it provides for one person to be a team leader and is responsibile for reaching conclusions and carrying them out, in effect, a case manager.

But then this comes back to the earlier question of what is driving the system — the insurance scheme or the rehabilitation needs of the injured worker. Only if the case manager is a trained rehabilitation counsellor and is responsible for making the decisions and carrying out the program can consistent and comprehensive service be guaranteed.

The justification for the decision to establish ISUs is that it is a form of regionalization. But one must wonder how an office in mid-town Toronto that serves all of Ontario, with the exception of those areas which have regional offices, can be termed regionalization. Surely staff serving the needs of injured workers within their geographic area have a greater understanding of the problems of the local community, especially those of employment and job demand, than employees in Toronto. Surely injured workers in these areas should not have to come to Yonge and Bloor in Toronto to see a counsellor and discuss work or personal problems.

Finally, where in the process does the injured worker fit? The WCB, in its huge monolithic system, will still gaze out of its glass-encased premises at the clients they are supposed to serve. The concept of the centrality of the worker has still not been recognized by the WCB.

ISUs may look good on paper. Putting people who work together in close proximity may reduce the need for multiple copies of files. It may even improve communications across the various divisions within WCB. But it fails to deal with the essential philosophy that must be accepted by the board:

1. The team leader must be the rehabilitation counsellor.
2. Regionalization means putting offices in the communities where the injured workers live and work. Staff must live and work locally so they become part of the community.
3. The injured worker must be included as part of the decision-making process. Rehabilitation cannot be imposed. The client must be the central agent in the process.

## Medical Rehabilitation

The Task Force also strongly agrees that medical rehabilitation services should be purchased in the local town or city from community hospitals under the Ministry of Health. Under the direction of the Task Force the Ontario Hospital Association conducted a survey of 73 Ontario hospitals (35% of OHA members) and found 49 hospitals across the province which would be willing and able to provide services on a fee-for-service basis.

| | |
|---|---|
| Metro area | 11 |
| Northern Ontario | 7 |
| Central Ontario | 15 |
| Eastern Ontario | 8 |
| Western Ontario | 8 |
| **Total** | 49 |

In fact, 34 hospitals said they could provide medical diagnostic services at the present time with existing resources and 43 indicated they could provide medical therapy.

Therefore the Task Force recommends:

66. That medical and functional assessment and therapeutic services be purchased from local community hospitals wherever possible. Where such services do not exist, the Minister of Labour should work closely with the Minister of Health to assist actively in the establishment of medical and functional assessment centres in the local communities.
67. That rehabilitation services, in all its facets, including medical, psychosocial, vocational and work adjustment, should be purchased by the case manager from community institutions, organizations or private services in the communities wherever they are available.
68. That when an appropriate rehabilitation service does not exist in the local community, the Workers' Compensation and Rehabilitation Board should assist actively with advice and financial incentives in the establishment of such services.
69. That the Workers' Compensation and Rehabilitation Board should decentralize its services and establish rehabilitation offices staffed by case managers and employment specialists in local communities as far as possible.

## *Northern Ontario*

As the Task Force travelled through Northern Ontario during its public hearings, visiting Thunder Bay, Sault Ste. Marie, Elliot Lake, Timmins, and Sudbury, it was impressed by a unique set of geographic, social and economic conditions.

The North includes a vast tract of land, remote, relatively small cities and towns, and an economy largely based on natural resources. It was quickly recognized that these conditions called for a rehabilitation service delivery model appropriate for the North.

Northern Ontario is defined as the geographic area bounded to the south by the Parry Sound District, to the north by Sub-Arctic Canada, to the east by Quebec and to the west by Manitoba.

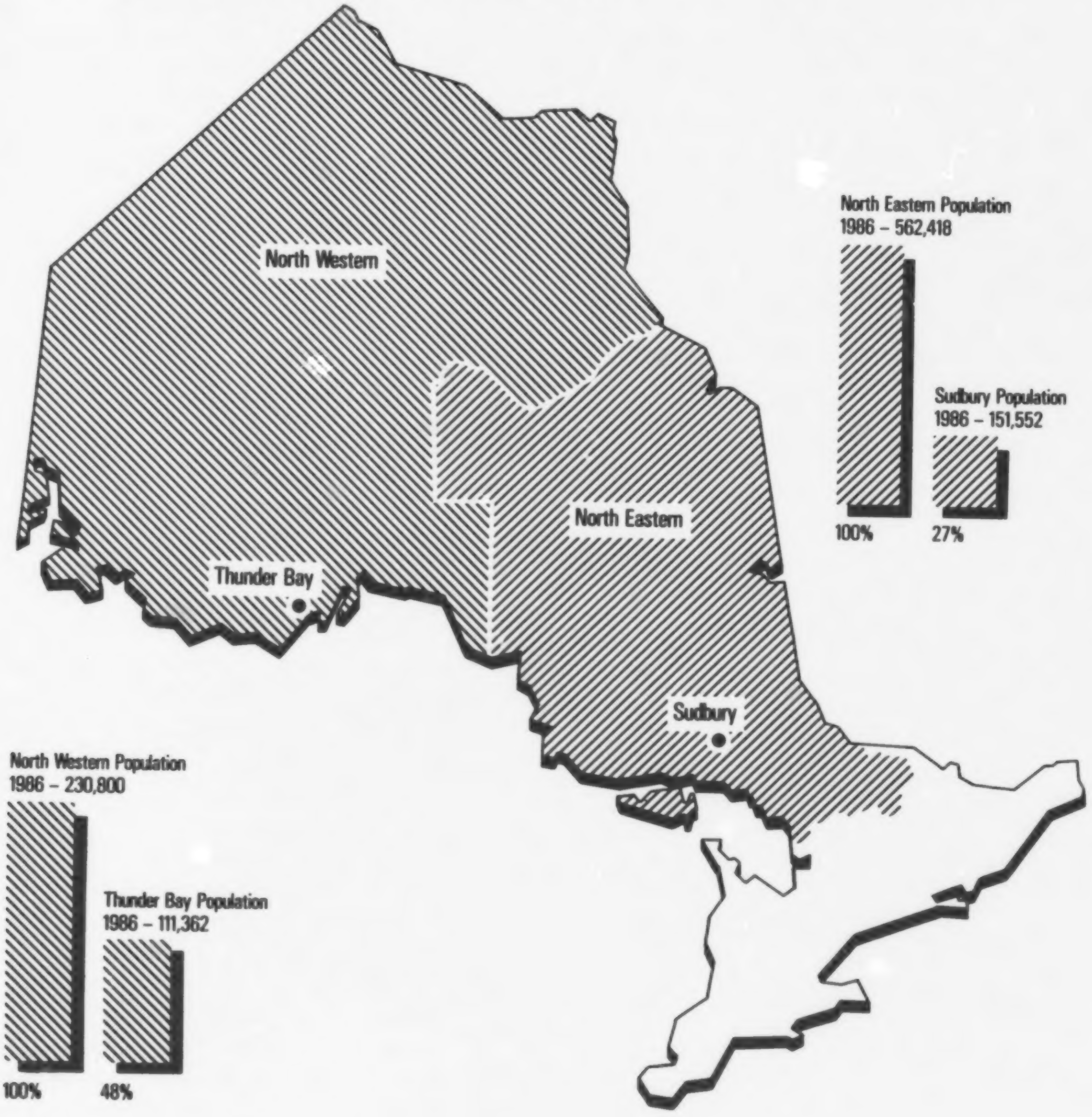
In 1986, Statistics Canada reported that 793,218 people lived in Northern Ontario, over an area of 932,400 square kilometers. This represents 88% of the land mass of the province with only 9% of the population, compared with Southern Ontario, which represents 12% of the land mass and 91% of the population.

Northern Ontario is subdivided into two main regions, the Northwest and the Northeast. The Northwest Region has a population of 230,800 (29% of the total for Northern Ontario), and comprises the Districts of Kenora/Rainy River and Thunder Bay. The Northeast Region holds the majority of the population within its boundaries with 562,418 (71% of the total for Northern Ontario), and includes the Districts of Algoma, Cochrane, Nipissing, Parry Sound, Sudbury/Manitoulin and Timiskaming.

## *Northern Study*

The Task Force recognized that a new form of service delivery was needed for injured workers in the North. During the public hearings one option that was put forward was the creation of a rehabilitation facility in the North that would cut down on the distance travelled by injured workers from the North to the Downsview Rehabilitation Centre in Toronto. Among others, this view was advocated by the Canadian Paperworkers Union. The Paperworkers argued that the decentralization of services was needed not only in the North, but elsewhere in the province.

## **Demographic Profile:** Thunder Bay and Sudbury within the North Western and North Eastern Regions


North Western
North Eastern
Thunder Bay
Sudbury
North Eastern Population
1986 – 562,418
Sudbury Population
1986 – 151,552
100%
27%
North Western Population
1986 – 230,800
Thunder Bay Population
1986 – 111,362
100%
48%

Source: 1981 Census

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> *It is unfortunate that the only rehabilitation centre is located in Toronto. While we must accept that there might be a need to centralize the organization of programmes, it is imperative to decentralize the distribution of services. The Workers' Compensation Board should conduct a feasibility study on the establishment of rehabilitation services in areas such as Thunder Bay, Sudbury, Ottawa and Windsor.*
>
> *Such a decentralization of operations would allow the establishment of job assessment services to determine what the injured worker is able to do.*
>
> Canadian Paperworkers Union
> Submission to Task Force

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While this position was one that was repeated again and again during the public hearings the message was also very clear that no one wanted to see a duplication of the Downsview Rehabilitation Centre on a smaller scale in the North.

Armed with these criteria the Task Force had to decide: (1) whether decentralized rehabilitation facilities should be opened in the North; (2) if so, where they should be located; and (3) who should be responsible for the management of such a facility.

To assist it with its task, the Task Force struck a Northern Sub-Committee, which consisted of its two Sudbury members, Mr. John J. Corrigan and Mr. Bernie Young. The Subcommittee commissioned a consultant's report to undertake the background information necessary to arrive at a set of recommendations.

The study found the WCB system of treating injured workers from Northern Ontario at the Downsview Rehabilitation Centre inadequate. Two predominant factors underlie the growing dissatisfaction with the high cost and time delays in the rehabilitation of injured workers from Northern Ontario.

First, the sheer distance and remoteness is a problem which is made worse when workers have to travel to Southern Ontario for assessment and treatment.

Second, there is a perception that the specialists in the South are unfamiliar with, and do not understand, the special conditions in the North, and so make unrealistic assumptions and set unattainable goals. The result is to emphasize the adversarial aspects of the system in a way which is in the interests of neither the employer nor the employee.

This lack of knowledge about the North on the part of the specialists at the DRC has led to inappropriate work assessments.

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> *I often will get a worker coming back, in particular a person who is a power saw operator or a skidder operator, and while at Downsview they have been given certain tests. It seems that they have explained to me they can test themselves if they can cut the tree. There is a log on... the saw-horse and they've been given a power saw and if they can cut this log for half an hour, they are able to come back to work. Our people are expected to cut over 100, basically 125 to 200 trees a day in rough ground. You know, standing on the green grass in the middle of a field is not comparable to his working environment. And this is extremely difficult for us because when a person has gone through this evaluation he has been deemed fit and able to return to work. Of course, when he comes back to us, we can very clearly see that he is not able to return to work.*
>
> Ms. Carol Anuk
> Great Lakes Forest Products
> Thunder Bay, October 20, 1986

❑ ❑ ❑

Currently, if resolution of incapacitation has not been achieved after 90 days post injury, the injured worker is usually asked to attend the Downsview Rehabilitation Centre. The injured worker is examined and treatment is re-assessed.

In 1986, 1,074 injured workers from the Northwest Region and 2,569 injured workers from the Northeast Region were off the job for eight weeks or longer. It is this group of injured workers that is of particular interest, because they customarily have required re-assessment and longer rehabilitation.

Furthermore, in the Northwest, 660 workers were disabled for longer than 90 days, while in the Northeast the number was 1,665 workers. If one calculates that no more than 60% of all these workers ultimately reach the Toronto facility and spend an average of 21 days of assessment and treatment in Downsview, this represents about 30,000 treatment days.

These days are spent away from the family and thus represent an additional hardship. They also represent a substantial cost in travel and lodging in addition to the necessary diagnosis and treatment costs.

The answer to this situation lies in establishing two rehabilitation facilities in the North, one in Thunder Bay to serve the Northwest and one in Sudbury to serve the Northeast. This is based on the recognition that these two cities: (1) have the greatest concentration of population and existing health care facilities and professionals in the North, and (2) represent the principal geographical locations for transportation and accessibility in their respective regions.

These rehabilitation facilities should be community based and managed. They would offer medical and functional assessment rehabilitation services that would be purchased by the Workers' Compensation and Rehabilitation Board.

Other rehabilitation services, such as vocational, would be purchased as needed within the local community. Therefore, these facilities would also have a major role in co-ordinating an injured worker rehabilitation program, with the injured worker's case manager at the Workers' Compensation and Rehabilitation Board.

## *Existing Services in Northern Ontario*

Tables 1 to 3 (see Appendix D) show the number of active treatment beds in the Northwest Region. Table 1 shows that the Thunder Bay District within the Northwest Region holds 1,195 of the 1,698 active beds, and that the Municipality of Thunder Bay holds the greatest single number at 389. Table 2 presents the corresponding breakdown for the Northeast Region. The number of active beds stands at 3,417, with the Municipality of Sudbury having the greatest single total at 865. Table 3 presents the totals for the two regions.

One of the key facets of a rehabilitation program are the group of health care professionals needed for the medical component. Tables 4 and 5 show the availability of physiotherapists, occupational therapists, and psychologists in the two northern Regions. Tables 6 and 7 exhibit a breakdown of health care personnel in addition to the above three professions. Once again, the greatest concentration exists in Thunder Bay in the Northwest and Sudbury in the Northeast.

It must be noted, however, that an ongoing shortage of health care professionals exists in the North in general.

Therefore, with the creation of rehabilitation facilities in Thunder Bay and Sudbury, it would be necessary to undertake a concerted effort to attract additional health care professionals.

## *Transportation Linkages*

The majority of residents in Northern Ontario can travel to Thunder Bay or Sudbury at comparatively little expense, compared to the cost of travelling to Toronto. The saving would be substantial to the Workers' Compensation and Rehabilitation Board in terms of transportation costs alone. There is also a reduction in the travellers' time, and in wear and tear on people who are not well able to withstand the rigours of travel.

Maps 1 through 4 (see Pages 177 – 180) with corresponding tables, show the availability of transportation routes and services to Thunder Bay and Sudbury from most Northern Ontario locations. The table on page 181 shows the costs of travelling to Toronto from a number of northern locations using the same form of transport.

Over long distances, air service costs are similar to those for automobile travel. With the exception of the James Bay and Hudson Bay districts, air travel costs are less than $200 to either Thunder Bay or Sudbury from their respective regions. Similar costs from the North to Toronto are much higher, varying anywhere from $224 to $556.

## Establishment of Rehabilitation Facilities

The Task Force concluded that the answer was not to establish small scale versions of the DRC in the North. The answer lies with the community-based and community-managed rehabilitation facilities that offer the services. Once established, the Workers' Compensation and Rehabilitation Board would, in turn, buy rehabilitation services from these regional community-based facilities.

At all times services would be purchased as close to the injured worker's home as possible. Thus, if an injured worker in Sault Ste. Marie needed physiotherapy for an injured arm and it was available in Sault Ste. Marie, then that is where it would be purchased. The injured worker would, therefore, not have to travel to the regional facility in Sudbury.

A model for a regional rehabilitation facility in Sudbury was being formulated by local community leaders during the proceedings of the Task Force. This local initiative is called the Northeastern Ontario Injured Workers' Rehabilitation Program (IWRP), headed by Mr. Mark Mieto, Director, Health and Social Services, Regional Municipality of Sudbury. This community-based initiative is comprised of representatives of business, labour, the municipality, and health care institutions that want to provide rehabilitation services for injured workers throughout the Northeast.

The Northeastern Ontario Injured Workers' Rehabilitation Program represents a significant community-based initiative to overcome the many shortcomings of the existing WCB rehabilitation system. The Task Force, therefore, strongly endorses the initiative and recommends that the Workers' Compensation and Rehabilitation Board, as a part of the community, provide initial start-up funding and then purchase services at an appropriate fee.

The mission statement of the IWRP, as proposed in their Operations and Management Plan is:

> *...to provide effective and well-coordinated rehabilitation services to the injured worker in the Sudbury area and to workers across the Northeast.*

Their stated objectives are:

Objective #1 — Fill the gaps in the existing system

- *assign rehabilitation staff/teams to provide client assessments and treatments as soon as medically feasible following referral;*
- *offer psycho-social counselling programs to assist clients in dealing with injuries, and to assist the teams in determining vocational rehabilitation needs; and*
- *provide follow-up to clients discharged from the IWRP and the Downsview Rehabilitation Centre to monitor rehabilitation success and workforce re-integration*

Objective #2 — Strengthen existing networks

- *encourage the coordination of patient services provided by clinical and rehabilitative care professionals; and*
- *develop education and prevention programs either solely or jointly with other organizations or groups*

Objective #3 — Provide support assistance to the tertiary and primary levels of care

- *provide support to the physicians in the region; and*
- *liaise with the Downsview Rehabilitation Centre (DRC) and provide relevant assessment and treatment information for those workers who attend DRC.*

It should be noted, of course, that this Task Force is of the very strong opinion that the DRC become a Class "J" Regional Rehabilitation Hospital, offering services to ambulatory patients only, with no overnight services, as set out by the Downsview Review Team in their report of April 27, 1987 to the Minister of Labour. Therefore, a formula for a northern rehabilitation facility should rely on local resources and not include the DRC in its planning.

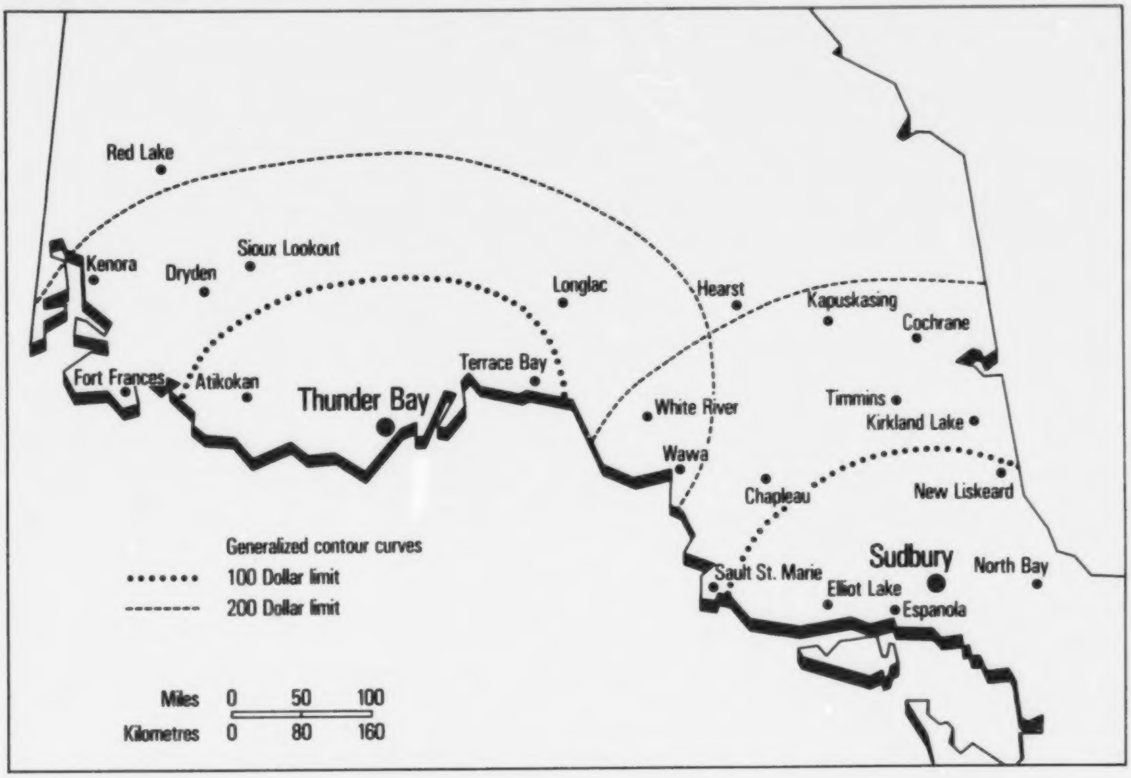
As it stands currently, the Northeastern Ontario Injured Workers' Rehabilitation Program is designed to operate through an exclusive medical referral system. This means that an injured worker can only be accepted into the facility if he/she is referred by a medical doctor. The Task Force strongly recommends a system where the WCB case manager can also be in a position to make a referral and place an injured worker into a rehabilitation program.

A unique service delivery system must be in place in Northern Ontario. The Task Force therefore recommends:

70. That community based regional rehabilitation facilities be established in Thunder Bay and Sudbury to provide rehabilitation services to injured workers in Northern Ontario, with:
    a) initial start-up funding provided by the Workers' Compensation and Rehabilitation Board, and
    b) that the Workers' Compensation and Rehabilitation Board purchase services on a appropriate fee-for-services basis.
71. That the Workers' Compensation and Rehabilitation Board case manager in conjunction with the Rehabilitation Facilities purchase rehabilitation services from the community.
72. That rehabilitation services be purchased as close as possible to the injured worker's residence.
73. That the Northeastern Ontario Injured Workers' Rehabilitation Program reassess its intention to be a medically driven facility and accept referrals from Workers' Compensation And Rehabilitation Board case managers.
74. That the community in Thunder Bay and the Northwest region, with an interest in the rehabilitation of injured workers, develop a rehabilitation facility using the community based model of the Injured Workers' Rehabilitation Program for Northeastern Ontario as a guide.
75. That the Minister of Labour, in conjunction with the Minister of Northern Development and Mines, the Minister of Health and the Minister of Colleges and Universities, develop programs and incentives that will encourage and assist students of Northern Ontario to enter into education and training in the health care field in greater numbers and to seek employment in their field of study and profession in Northern Ontario.
76. That the Minister of Labour, in conjunction with the Ministers of Intergovernmental Affairs, Northern Development and Mines, and Health, undertake discussions with their federal government counterparts to provide the incentive for the possible migration of health care professionals who wish to practice in Northern Ontario.

## Auto Travel

### Northern Ontario (standard round trip fares) February 1, 1987


Red Lake
Kenora
Dryden
Sioux Lookout
Longlac
Hearst
Kapuskasing
Cochrane
Fort Frances
Atikokan
Thunder Bay
Terrace Bay
White River
Timmins
Kirkland Lake
Wawa
Chapleau
New Liskeard
Sault St. Marie
Sudbury
North Bay
Elliot Lake
Espanola
Generalized contour curves
100 Dollar limit
200 Dollar limit
Miles 0 50 100
Kilometres 0 80 160

### Return Automobile Travel Costs Based on 20¢ per Kilometre

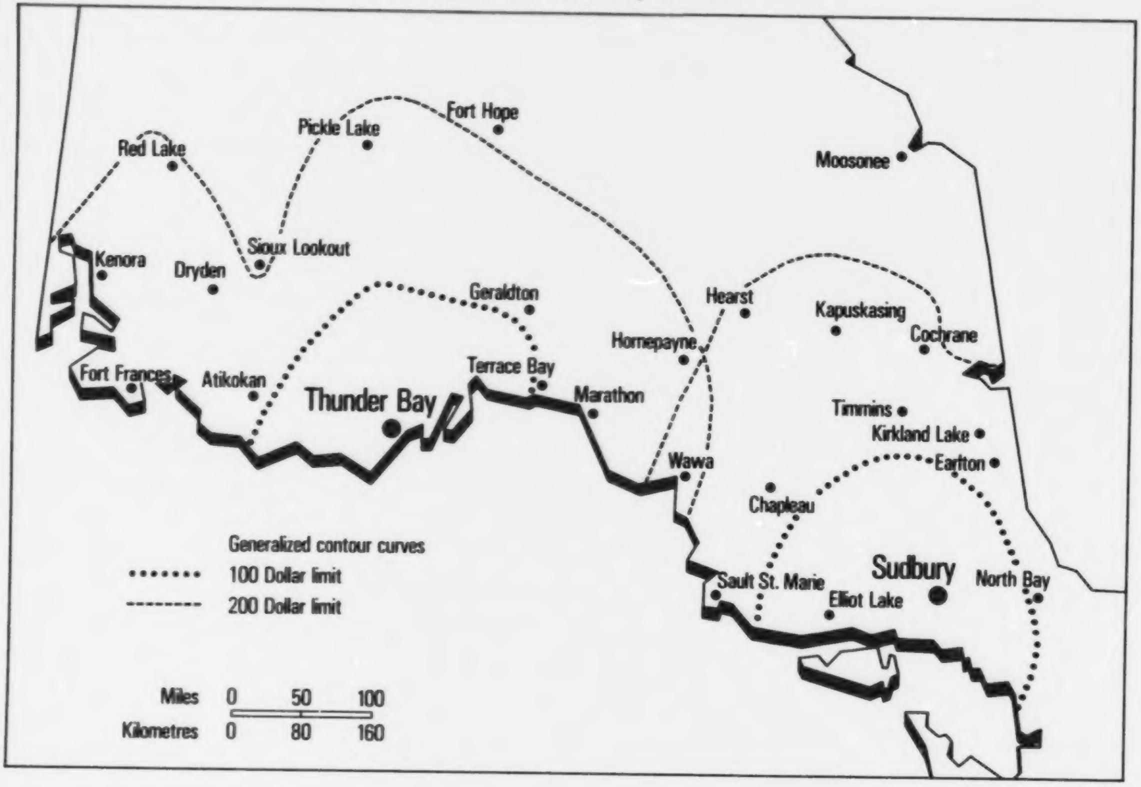
| Sudbury to: | $ |
|---|---|
| Espanola | 28.00 |
| North Bay | 50.00 |
| Elliot Lake | 64.00 |
| New Liskeard | 90.00 |
| Timmins | 116.00 |
| Sault Ste. Marie | 122.00 |
| Kirkland Lake | 126.00 |
| Cochrane | 152.00 |
| Chapleau | 164.00 |
| Kapuskasing | 184.00 |
| Hearst | 220.00 |

| Thunder Bay to: | $ |
|---|---|
| Atikokan | 76.00 |
| Terrance Bay | 86.00 |
| Longlac | 120.00 |
| Fort Francis | 134.00 |
| Dryden | 136.00 |
| Sioux Lookout | 148.00 |
| White River | 152.00 |
| Wawa | 182.00 |
| Kenora | 192.00 |
| Red Lake | 222.00 |

*Source: Calculated from information provided by CAA Auto Club & Travel Agency, Sudbury.*

## Air Service

Northern Ontario (standard round trip fares) February 1, 1987


Red Lake
Pickle Lake
Fort Hope
Moosonee
Kenora
Dryden
Sioux Lookout
Geraldton
Hearst
Kapuskasing
Cochrane
Hornepayne
Fort Frances
Atikokan
Thunder Bay
Terrace Bay
Marathon
Timmins
Kirkland Lake
Wawa
Earlton
Chapleau
Sudbury
Sault St. Marie
Elliot Lake
North Bay
Generalized contour curves
100 Dollar limit
200 Dollar limit
Miles 0 50 100
Kilometres 0 80 160

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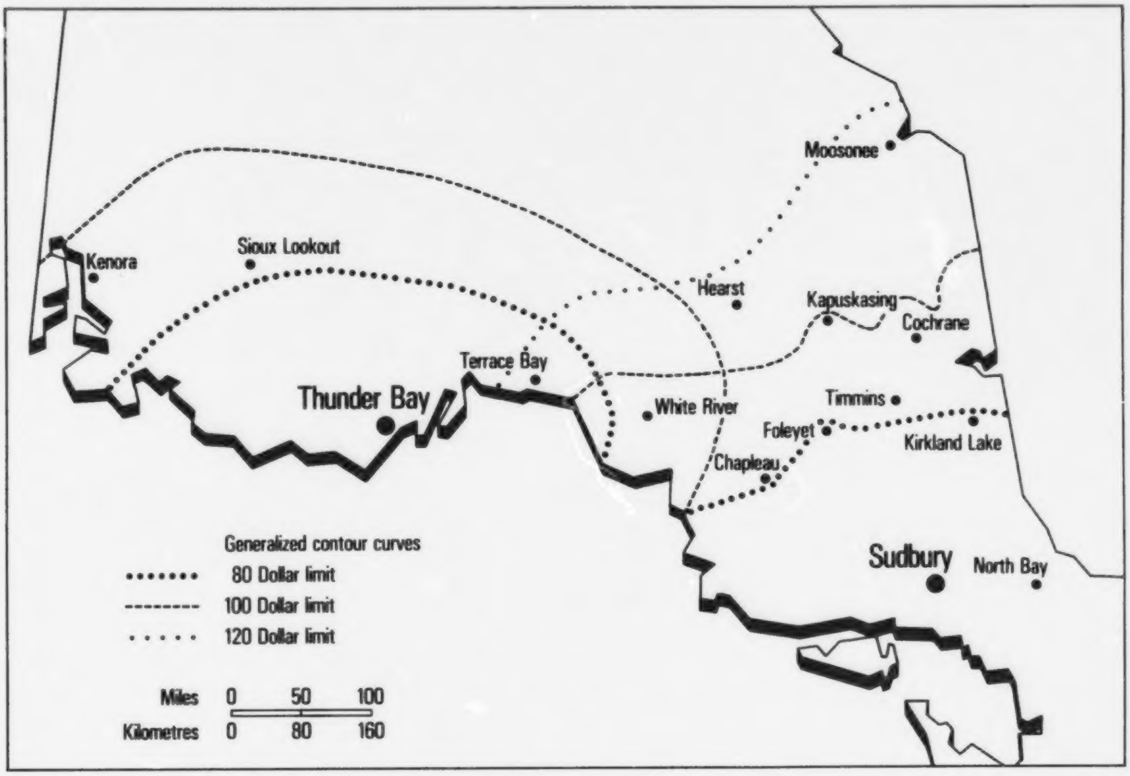
### Return Air Service Costs (Norontario and Austin)

| Sudbury to: | $ | Thunder Bay to: | $ |
|---|---|---|---|
| North Bay | 104.00 | Atikokan | 118.00 |
| Earlton | 110.00 | Terrace Bay | 118.00 |
| Elliot Lake | 110.00 | Geraldton | 132.00 |
| Kirkland Lake | 126.00 | Marathon | 146.00 |
| Timmins | 128.00 | Fort Francis | 150.00 |
| Chapleau | 130.00 | Pickle Lake | 150.00 |
| Sault Ste. Marie | 142.00 | Hornepayne | 162.00 |
| Kapuskasing | 146.00 | Dryden | 170.00 |
| Wawa | 170.00 | Kenora | 170.00 |
| Hearst | 186.00 | Red Lake | 202.00 |
| Cochrane | 214.00 | Sioux Lookout | 214.00 |
| Moosonee | 304.00 | Fort Hope | 296.00 |

*Source:* *CAA Auto Club & Travel Agency, Sudbury.*

## Rail Service

### Northern Ontario (standard round trip fares) February 1, 1987


Moosonee
Kenora
Sioux Lookout
Hearst
Kapuskasing
Cochrane
Terrace Bay
Thunder Bay
White River
Timmins
Foleyet
Kirkland Lake
Chapleau
Sudbury
North Bay
Generalized contour curves
80 Dollar limit
100 Dollar limit
120 Dollar limit
Miles 0 50 100
Kilometres 0 80 160

---

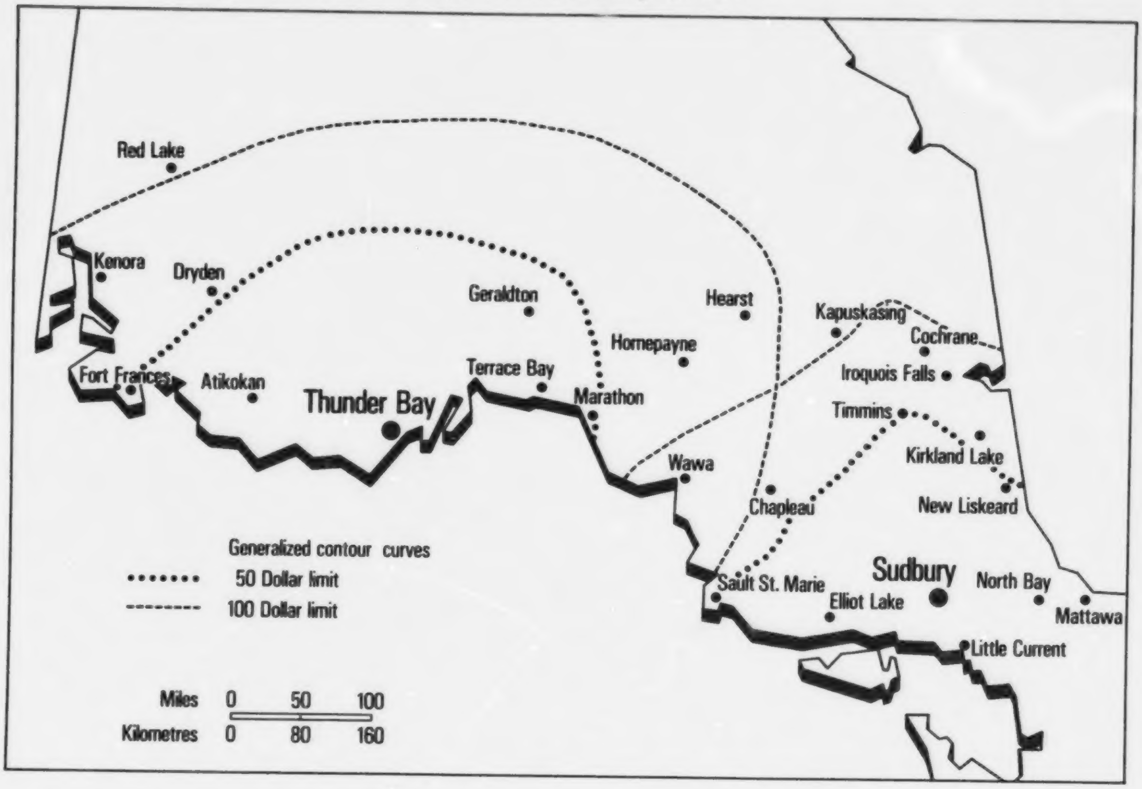
### Return Rail Passenger Costs (Via Rail)

| **Sudbury to:** | $ | **Thunder Bay to:** | $ |
|---|---|---|---|
| North Bay | 18.00 | Terrace Bay | 38.00 |
| Foleyet | 48.00 | Sioux Lookout | 58.00 |
| Chapleau | 54.00 | White River | 64.00 |
| Kirkland Lake | 66.00 | Kenora | 86.00 |
| Timmins | 86.00 | | |
| Cochrane | 88.00 | | |
| Kapuskasing | 112.00 | | |
| Moosonee | 132.00 | | |
| Hearst | 134.00 | | |

*Source:* *Via Rail.*

## Bus Service

### Northern Ontario (standard round trip fares) February 1, 1987


Red Lake
Kenora
Dryden
Geraldton
Hearst
Kapuskasing
Cochrane
Hornepayne
Iroquois Falls
Fort Frances
Atikokan
Thunder Bay
Terrace Bay
Marathon
Timmins
Kirkland Lake
Wawa
Chapleau
New Liskeard
Generalized contour curves
•••••• 50 Dollar limit
-------- 100 Dollar limit
Sault St. Marie
Sudbury
North Bay
Elliot Lake
Mattawa
Little Current
Miles 0 50 100
Kilometres 0 80 160

### Return Bus Service Costs

| Sudbury to: | $ |
|---|---|
| Little Current | 20.50 |
| North Bay | 22.40 |
| Elliot Lake | 28.40 |
| Mattawa | 36.10 |
| New Liskeard | 49.50 |
| Sault Ste. Marie | 49.50 |
| Timmins | 49.50 |
| Kirkland Lake | 64.10 |
| Iroquois Falls | 83.00 |
| Chapleau | 85.10 |
| Wawa | 89.70 |
| Cochrane | 90.80 |
| Kapuskasing | 111.10 |

| Thunder Bay to: | $ |
|---|---|
| Terrace Bay | 23.10 |
| Atikokan | 28.00 |
| Geraldton | 38.20 |
| Fort Francis | 48.90 |
| Marathon | 49.50 |
| Dryden | 53.10 |
| Hornepayne | 60.00 |
| Hearst | 73.20 |
| Kenora | 73.60 |
| Red Lake | 113.20 |

*Source:* *Union Bus Depot, Sudbury.*

## Northern Ontario — Toronto Travel Cost Comparisons
## (Return)

| | | $ |
|---|---|---|
| **Air Service (round trip economy)** | | |
| Toronto to: | Sudbury | 224.00 |
| | Thunder Bay | 354.00 |
| | Moosonee | 528.00 |
| | Red Lake | 556.00 |
| **Rail Service (round trip standard economy)** | | |
| Toronto to: | Sudbury | 74.00 |
| | Moosonee | 174.00 |
| | Thunder Bay | 186.00 |
| | Kenora | 244.00 |
| **Bus Service** | | |
| Toronto to: | Sudbury | 69.00 |
| | Kapuskasing | 153.00 |
| | Thunder Bay | 172.00 |
| | Red Lake | 294.00 |
| **Automobile (based on 20 cents per kilometre)** | | |
| Toronto to: | Sudbury | 156.00 |
| | Kapuskasing | 340.00 |
| | Thunder Bay | 550.00 |
| | Red Lake | 772.00 |

*Source:* *Data provided by CAA Auto Club & Travel Agency, Sudbury.*

## Chapter 15

# Non–Urban, Non–Industrial Sector

- *the Native community*
- *the agricultural sector*
- *summary*

* * *

> *The band operates on a limited budget. We would really like to have everyone covered by Workers' Compensation but we cannot afford it. Self-employed persons who become injured are not covered at all.*
>
> Band Member
> (Source: *Workers' Compensation Board and the Indian Community in Ontario*)

* * *

> *We would suggest that many of these individuals who are paying for WCB coverage are unaware of the variety of services available to an injured worker and his family. We would recommend that effort directed towards providing more information on WCB benefits and correcting the perception that it is designed primarily for the industrial sector.*
>
> Ms Nancy McGill
> Ontario Federation of Agriculture
> North York, December 11, 1986

* * *

During the course of its investigations, the Task Force found the WCB had not developed a particularly good relationship with two major communities, the Natives and the agricultural sector.

## The Native Community

Following the completion of its public hearings, the Task Force recognized that one community it had not heard from was the Native community in Ontario. ("Native" refers to registered status Indians, non-status Indians, Metis and Inuit).

The Task Force therefore commissioned a study to investigate what, if any, relationship existed between the WCB and Native communities on Indian Reserves in Ontario. The study found a breakdown in communications and a very poor record of WCB service delivery.

A reserve is a tract of land set aside for the use and benefit of a band, the legal title of which is vested in the Crown. A band is a body of Indians recognized by government for whose benefit and use land and money have been set aside and held by the Crown. A band is managed by an elected band council. In 1984, 77,313 registered Indians lived in Ontario, 0.9% of the total Ontario population. Of this amount, 31.9% resided off-reserve. In 1985, there were 185 reserves and settlements in Ontario.

During the research for the study the following Bands were consulted: Big Trout Lake, Garden River, Grassy Narrows, Kingfisher Lake, Sandy Lake, Serpent River, Shoal Lake, Spanish River, St. Regis, Walpole Island, Whitefish Bay and Wikwemikong. In addition to the above, the following organizations were consulted: Association of Iroquois and Allied Indians, Chiefs of Ontario (Health), Native Canadian Friendship Centre of Toronto (Legal Services) and Treaty Three.

These discussions resulted in the presentation of a jumbled and incoherent picture. Some bands paid WCB assessments while others did not. In some cases projects were abandoned because the Band Council could not pay the premium assessment.

In general, bands were unaware of the availability of WCB services to injured workers or had difficulty classifying the type of work performed by Band employees. As a result, band members turned to unemployment insurance or welfare for help when an injury occurred.

In its review of the study findings, the Task Force found that poor communication and the WCB's lack of understanding of this community paralleled many of the concerns raised by the Ontario Federation of Agriculture.

## The Agricultural Sector

Like the Native community, the agricultural sector's relationship with the WCB has been marred by poor communications, lack of understanding, and poor service delivery. According to the Ontario Federation of Agriculture, which represents over 24,000 farm family members:

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> *... many farmers are not aware of the services available to workers and employers under the Workers' Compensation Board, and in particular those available through the vocational rehabilitation division. The WCB is often perceived to be designed to primarily serve the needs of the industrial and service sectors.*
>
> Ontario Federation of Agriculture
> North York, December 11, 1986

❑ ❑ ❑

As a result of the perception that the WCB is designed to serve the industrial and service sectors many owners/operators (who are themselves largely covered by private insurance plans) are unaware of the variety of services available to an injured worker or a family member who is receiving a wage for working on the farm.

An injury to a working member of a family farm can disrupt the whole operation of the farm due to the nature of its workplace. This point was stressed by the Ontario Federation of Agriculture which argued that the WCB needed trained staff who had at least a minimum understanding of the different production techniques and practices used in the agricultural sector.

❑ ❑ ❑

> *The family farm perhaps more than any other workplace can be severely affected by the injury of a worker. Usually a farm has a small, highly skilled work force. Any injury to the owner/operator or hired labour can cause a major disruption to the whole farm family. On a dairy farm cows can not simply be shut down nor can crops wait in the field. Should the operator suffer a long-term disability there is additional stress as the family faces the prospect of not only losing their farm but their home and way of life.*
>
> Ontario Federation of Agriculture
> North York, December 11, 1986

❑ ❑ ❑

## Summary

The Task Force found the conditions that presently exist between the two groups and the WCB of sufficient concern to warrant special attention. The information the Task Force reviewed led it to the conclusion that those groups that do not fit into the urban industrial mould have an unsatisfactory relationship with the WCB. This should not exist with a publicly run institution.

The Task Force fully believes that the WCB is also neglecting the needs of other sectors, such as domestics, hunters, trappers and fishermen.

The Task Force, therefore, recommends the following:

77. That the Workers' Compensation and Rehabilitation Board initiate a dialogue with representatives of Native Bands to discuss the present rating schedule and rehabilitation needs of the community, taking into account such factors as the unique socioeconomic existence of Natives in Ontario.
78. That the Workers' Compensation and Rehabilitation Board initiate a dialogue with representatives of the agricultural community towards providing rehabilitation services that are relevant, accessible, and appropriate for that community.
79. That the Director of Communications of the Workers' Compensation and Rehabilitation Board Rehabilitation Division develop channels of communication between the Workers' Compensation and Rehabilitation Board and the Native community and the agricultural sector, with the goal of establishing the following:
    - a discussion of benefits and costs, and the potential usefulness of rehabilitation;
    - clear and complete guidelines for undertaking coverage by Workers' Compensation and Rehabilitation Board and making full use of its services and benefits;
    - an outline of these services and benefits as they apply to Native people in urban, rural, and remote settings, and to traditional and non-traditional forms of work;
80. That the Workers' Compensation and Rehabilitation Board identify other non-industrial and non-urban sectors or communities, such as the fishing industry and non-Native hunters and trappers in Ontario, and ensure that effective lines of communication exist or are established so that rehabilitation services to these sectors are relevant and effective.

## Chapter 16

# Final Statement

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*What I would like to ask is why it takes so long when the word rehabilitation gets to the Compensation Board's attention. I've been waiting two years exactly as of the 16th of November, 1984 for them to be in touch with me. I've never heard a word from them as yet.*

Mr. Norm Gilmour
Injured Worker
Peterborough, November 19, 1986

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*It is our firmly held view that the underlying principles of early intervention and accountability are the key to effective rehabilitation programs. Under the present WCB system, these principles are lacking. Consequently, the vocational rehabilitation services of the board fall short in its objective to facilitate the workers' return to the workplace and the community at the earliest opportunity.*

Mr. Mark Nantais
Motor Vehicle Manufacturers' Association
Toronto, December 9, 1986

❑❑❑

The experience of the Task Force in the past year was long, painful and emotionally wrenching. The tales of injustice, neglect and rejection recounted by the injured workers throughout the province were so harrowing as to leave the Task Force members disgusted and frustrated.

Presentations from employers, unions, legal clinics and health professionals served to confirm the stories of the injured workers. The 11 studies commissioned to investigate various aspects of rehabilitation identified the existence of a large gap between the philosophy and statistics of the WCB than the one presented to the public and the actual service delivery.

The WCB has moved somewhat from the philosophy it held when it was first established. It has become somewhat more caring, more interested in the welfare of injured workers and more willing to invest in improving the quality of its services. But it has failed to recognize the emergence of a society that is more understanding of the needs of the disabled. It has failed to become responsive to the fact that hundreds of thousands of workers have become partially or totally disabled in the past years and that society cannot ignore or reject them.

Some of the problems point to legislation that governs service delivery. The *Workers' Compensation Act* was written to eliminate the need for litigation and the search for blame in worksite accidents. It is concerned almost entirely with the concept of an insurance scheme and only slightly with the rehabilitation of the injured worker.

But in the 1980s society accepts its responsibility to care for injured workers as human beings, not merely as cogs in industrial wheels. It is not sufficient to restore them physically and then return them to the potentially unsafe working conditions from which they came, or to discard them with woefully inadequate pensions.

Clearly the Act must be rewritten to reflect the needs of the workers — needs not only for work but for dignity and a quality of life equal to what they had before the injury.

Of course, the main thrust of the Task Force's report has been on the rehabilitation of the injured worker. However, we feel that safety is the cornerstone of rehabilitation and share the concern of the Minister of Labour, who has commissioned a number of studies on safety associations. While the amount of money invested in safety associations has risen over the years and employment levels have remained relatively constant, the rate of accidents has increased dramatically.

Therefore, the Task Force recommends:

81. That a re-evaluation be made on the targeting of safety dollars.

Some of the blame must also be directed towards the WCB itself. The vagueness of the Act allows for interpretations that can work for the benefit of injured workers or to begrudge them services. For example, the Act states that the WCB may "assist in lessening or removing any handicap resulting from their injuries". The vagueness of "any handicap" allows the WCB to express either a caring attitude towards the injured worker in all the aspects of impairment or a grudging attitude which restricts the services offered.

The Act also states that "the Board may take such measures" allowing it to determine eligibility criteria and methods of refusing service. To date the Board has proven itself stingy in offering care and dignity to the injured workers.

In the Task Force's opinion, the WCB does not spend its funds on vocational rehabilitation effectively which hampers its ability to meet its stated goals. This has a number of important implications.

- referrals to Vocational Rehabilitation Division are kept to a minimum
- those who are referred are offered such services as retraining as a last resort, and then only if they are younger and better educated
- the Vocational Rehabilitation Division has a high rate of recidivism and closures (where further rehabilitation is deemed unnecessary)
- when recidivism and closures are taken into account, about 60% of VRD clients do not become re-employed. (Even this figure is conservative since there is no follow-up to determine how many, in fact, stay employed. As it stands, the board considers them "employed" unless they re-enter the system.)

In effect, the WCB does not serve the rehabilitation needs of all injured workers and those who are referred are served inadequately. To meet its existing goals (not to mention those of the Task Force), the WCB cannot continue to make cost control the primary force behind service delivery. As we have seen, this attitude only leads to an adversarial system fraught with litigation and unemployment for the injured worker.

Therefore, the board must be reconstituted to reflect concern with rehabilitation. The organizational structure must be altered to give prominence to the needs of its clients. Its staff must be hired and shaped into delivering a comprehensive, timely service that reflects a total rehabilitation model rehabilitation in all aspects of impairment.

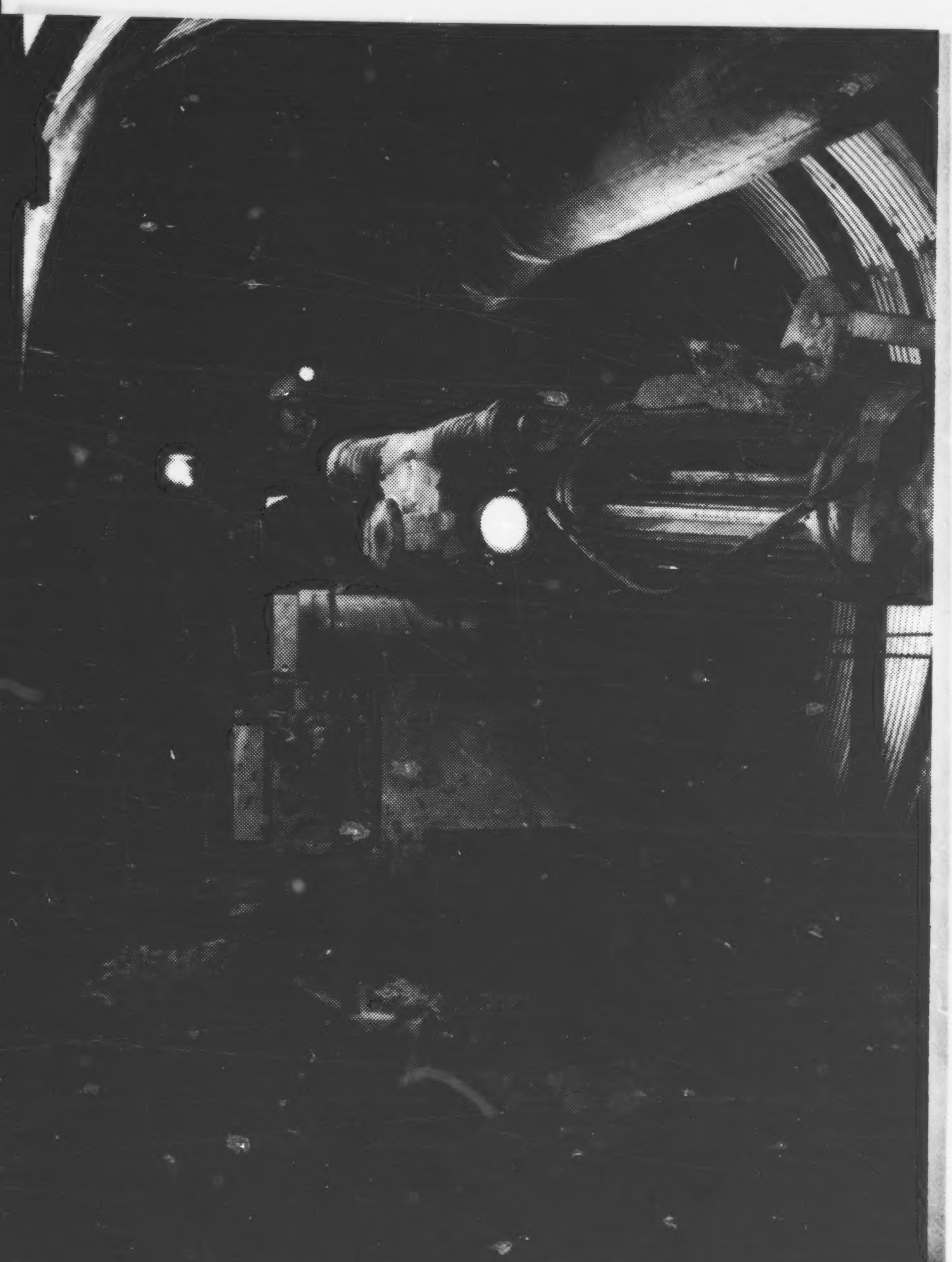
Many employers must also be faulted. It is almost as if once they pay their assessments there is no further responsibility for either prevention or re-employment. Employers ought to do far more than paying their premiums to ensure the wellbeing of their workers. Compensation has become a cheap insurance system for some employers, rather than a system of justice for injured workers.

Clearly there are unions, employers and groups of injured workers who have taken a leadership role in attempting to change the system. However, there are far too many who do no more than is required by law.

Changing a monolithic system such as the WCB requires involvement by caring persons at all levels. But, first of all, it requires the government to enact new legislation and translate it into change throughout the system.

Therefore the Task Force recommends:

82. That rehabilitation be enshrined in the Act as Regulation 949 under the *Workers' Compensation Act*.
83. That a tri-partite committee (labour, industry and government) be established to convert the Vocational Task Force recommendations into regulations to ensure they reflect the intent of the Task Force Report.
84. That a tripartite committee (labour, industry and government) be established, either as a standing review committee or otherwise, with the power to make amendments, adjustments and recommendations to the regulations.



## Chapter 17

# The Situation at Present

- *WCB Mission Statement*
- *corporate structure*
- *types and numbers of claims*
- *injured workers referred to Vocational Rehabilitation Division*
- *WCB and Vocational Rehabilitation Division*
- *Vocational Rehabilitation Division Mission Statement*
- *existing process and access to Vocational Rehabilitation Services*
- *more ineligibility criteria*
- *organization of the Vocational Rehabilitation Division*
- *description of counselling staff*

❑❑❑

*I think that the counsellors don't do more than what they are supposed to do. I was very traumatized working with my counsellor...I started to think that rehabilitation has nothing to do with compensation. After a big fight and wait...I finally got my English course that I was asking for four years.*

Mr. Carlos Beato
Injured Worker
Toronto, November 12, 1986
(Translation)

❑❑❑

*Rehabilitation deserves the trust and faith of the injured worker, and this cannot be fostered in an atmosphere of threats and intimidation. We believe that the rehabilitation services of the board should be separated entirely from claims adjudication and become the second fundamental cornerstone of the system.*

Mr. Sean O'Flynn
Secretary–Treasurer
Ontario Federation of Labour
Mississauga, December 12, 1986

❑❑❑

During the course of the Task Force's proceedings, the Workers' Compensation Board has undergone a number of structural changes, such as regionalization, introducing regionally oriented integrated service units, and the establishment of a number of medical rehabilitation clinics across the province from which the Workers' Compensation Board would then purchase services.

Despite these structural changes the Task Force was able to get a clear picture of its structure and budget and will present it to provide a conceptual framework. The intention of this section is to provide a factual overview, followed by a detailed critique.

## WCB Mission Statement

First of all, what is the defined goal of the Workers' Compensation Board? The following mission statement was presented in a staff discussion paper as recently as February of this year:

*Within the letter and the spirit of the* Workers' Compensation Act, *the Board is charged with the responsibility:*

1. *To provide income maintenance to workers sustaining or affected by occupationally related injuries or illnesses when the worker is unable to return to work.*
2. *To provide a high level of medical and vocational rehabilitation service to assist injured workers and to achieve maximal recovery and the ability to return to the work force.*
3. *To promote occupational health and safety education through proactive and province–wide safety activities.*
4. *To deliver Board programs effectively and efficiently having regard for the integrity of the accident fund.*

## Corporate Structure

To achieve these goals the Workers' Compensation Board is organized along a corporate model with a chairperson, board of directors, president, and three vice–presidents:, (1) Client Services, (2) Policy Planning, Special Services, (3) Corporate Services (see chart on page 207).

The Vocational Rehabilitation Division is headed by an executive director who reports to the vice–president for Client Services (see chart on page 208).

## Types and Number of Claims

There are two basic types of claims that can be made with the Workers' Compensation Board. The first is a lost–time claim, which in 1985 accounted for 44.2% or 188,461 of total new claims accepted by the board. A lost–time claim means that the injured worker receives some type of compensation.

Alternatively, a no–lost–time claim refers to a claim where the injured worker required health care treatment only. During 1985, no lost–time claims accounted for 48.5 percent or 207,104 of all claims.

The following table shows the number of lost–time claims and no–lost–time claims as well as denied claims for 1980 to 1985.

### Table 1

### Volume and Type of Claims, 1980 - 1985

*Number of Claims and Percentage of Total Claims*

| | 1980 | | 1981 | | 1982 | | 1983 | | 1984 | | 1985 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claims | % | Claims | % | Claims | % | Claims | % | Claims | % | Claims | % |
| Allowed lost-time claims | 165,221 | 37.1 | 163,366 | 39.4 | 148,713 | 42.5 | 147,666 | 42.8 | 172,002 | 44.2 | 188,461 | 44.2 |
| Allowed no lost-time claims | 246,255 | 55.4 | 222,374 | 53.6 | 183,990 | 52.6 | 175,871 | 51.0 | 192,919 | 49.6 | 207,104 | 48.5 |
| Denied Claims | 28,332 | 6.4 | 25,582 | 6.1 | 15,842 | 4.5 | 16,989 | 4.9 | 20,343 | 5.2 | 24,020 | 5.6 |
| Other (including withdrawn or pending claims) | 4,866 | 1.1 | 3,722 | 0.9 | 1,202 | 0.4 | 4,232 | 1.3 | 3,581 | 1.0 | 7,295 | 1.7 |
| **Total Claims** | 444,674 | 100.0 | 415,044 | 100.0 | 349,747 | 100.0 | 344,758 | 100.0 | 388,845 | 100.0 | 426,880 | 100.0 |

*Source:* *1985 Workers' Compensation Board Annual Report*

### Table 2

### Injured Workers Referred for Vocational Rehabilitation, 1980 - 1985

| | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 |
|---|---|---|---|---|---|---|
| Injured Workers | 5,707 | 6,545 | 7,652 | 8,126 | 7,633 | 11,269 |

*Source:* *1985 Workers' Compensation Board Annual Report*

## *Injured Workers Referred to the Vocational Rehabilitation Division*

During the course of 1985, 11,269 injured workers from across Ontario were referred for vocational rehabilitation services at the board. The table above shows the number of injured workers referred for vocational rehabilitation services from 1980 to 1985.

## *WCB and the Vocational Rehabilitation Division*

In 1985 (the last year for which published figures are available) the total WCB budget stood at *$1,167,814,000*. Of that amount *$15,855,082* was spent by the Vocational Rehabilitation Division. This represents 1.4% percent of the total W.C.B. Budget.

The following table breaks down the Vocational Rehabilitation Division budget from 1982 to 1986, in actual dollars and as a percentage of the total.

### Table 3

## Vocational Rehabilitation Division Spending

| | 1982 | 1983 | 1984 | 1985 | 1986 |
|---|---|---|---|---|---|
| | $ | $ | $ | $ | $ |
| Divisional Executive | 971,150 | 1,018,421 | 839,219 | 917,390 | 361,352 |
| Vocational Counselling | 4,160,649 | 4,428,564 | 5,572,854 | 6,379,150 | 7,130,874 |
| Rehabilitation Resources | 3,787,446 | 4,159,429 | 3,860,863 | 4,646,543 | 5,221,109 |
| Employment Services | 1,305,953 | 1,394,875 | 1,534,194 | 1,855,873 | 2,093,703 |
| Policy and Program Development | 173,830 | 197,869 | 244,635 | 765,557 | 972,550 |
| **Sub-Total** | 10,399,028 | 11,199,158 | 12,051,765 | 14,564,513 | 15,779,588 |
| VRS Sudbury | 432,823 | 521,342 | 644,998 | 770,676 | 796,445 |
| VRS London | 385,350 | 428,004 | 490,307 | 519,893 | 549,939 |
| **Grand Total** | 11,217,201 | 12,148,504 | 13,187,070 | 15,855,082 | 17,125,972 |

## Vocational Rehabilitation Division Spending

| | % of 1982 Total | % of 1983 Total | % of 1984 Total | % of 1985 Total | % of 1986 Total |
|---|---|---|---|---|---|
| Divisional Executive | 8.66 | 8.38 | 6.36 | 5.79 | 2.11 |
| Vocational Counselling | 37.09 | 36.45 | 42.26 | 40.23 | 41.64 |
| Rehabilitation Resources | 33.75 | 34.27 | 29.28 | 29.31 | 30.49 |
| Employment Services | 11.64 | 11.48 | 11.63 | 11.71 | 12.23 |
| Policy and Program Development | 1.55 | 1.58 | 1.86 | 4.83 | 5.68 |
| **Sub-Total** | 92.70 | 92.16 | 91.39 | 91.87 | 92.14 |
| VRS Sudbury | 3.86 | 4.23 | 4.89 | 4.85 | 4.65 |
| VRS London | 3.44 | 3.62 | 3.72 | 3.28 | 3.21 |
| **Grand Total** | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 |

## Vocational Rehabilitation Division Mission Statement

Before explaining how an injured worker gains access to vocational rehabilitation services and how the process works, the stated goal and objectives of the program as they exist at the present time must be identified.

The Vocational Rehabilitation Division defines its goal as follows:

> *Provide measures and opportunities to achieve the most effective possible restoration of the injured worker to an earning capacity and a place in the community.*
>
> (Vocational Rehabilitation Division, *Board Policies and Divisional Administration Guidelines, 01-01-02,* Nov. 26, 1982.)

The stated objectives are:

- *Develop and promote understanding and the active participation of industry, unions, treatment agencies, medical profession, government agencies and Ministries, community groups and the public at large in the vocational rehabilitation process.*
- *Maintain progressive and responsive vocational rehabilitation services.*
- *Undertake the responsibility of helping the industrially-injured worker to help herself/himself toward the restoration of renewed confidence, independence and the achievement of self-realization. (01-01-02,* Nov. 26, 1982*)*

This goal and objectives of the present Vocational Rehabilitation Division are based on the following definitions of rehabilitation:

> *A very acceptable but sweeping definition of rehabilitation in the broad sense is that it is the cultivation, restoration and conservation of human resources, assisting those who are handicapped by disease, disability or social maladjustment to achieve a state of maximum well-being.*
>
> *There are thus three major divisions of rehabilitation: the medical, the social and the vocational. Our duties are centred on the latter division of responsibility. In order to accomplish it, great attention must be paid to the medical forms of rehabilitation. Vocational Rehabilitation is also closely allied with the broad sphere of social rehabilitation; one cannot proceed without the other. (01-01-02,* Nov. 26, 1982*)*

The philosophical underpinnings of the Vocational Rehabilitation Division, as accepted by the board, are stated as follows:

- *The cultivation, conservation and restoration of the knowledge, skills, attitudes and physical well-being of the injured worker.*
- *The use of all appropriate sciences and disciplines to aid persons handicapped by social maladjustment arising out of the condition.*
- *The provision of vocational rehabilitation services to enable the injured worker to become capable of pursuing gainful employment and/or to aid in lessening any handicap resulting from the compensable injury or condition. (01- 01-01,* Nov. 26, 1982*)*

## Existing Process and Access to Vocational Rehabilitation Services

Injured workers can gain access to the services of the Vocational Rehabilitation Division in a number of ways. (A guide to the organizational flowchart is provided in Appendix E.)

To qualify for assistance, the injured worker must have an approved WCB claim. According to the *Claims Adjudication Branch Procedures Manual,* an allowable claim must have five elements:

1. an employer
2. a worker
3. personal injury arising out of and in the course of employment
4. proof of accident
5. compatibility of diagnosis to accident history

Most prevalent type referrals occur when an injured worker is deemed by the attending physician to be capable of light or modified work. At this point a *claims adjudicator* contacts the accident employer to determine if there is a job for the injured worker. Only if he or she does not have a job will the worker be considered for vocational rehabilitation services.

The claims adjudicator, a clerical position in the claims adjudication branch, will then screen the worker for eligibility for VR services according to the following criteria:

1. Whose compensable permanent disability prevents a return to the usual occupation.
2. Who is temporarily partially disabled due to a compensable condition and receiving compensation benefits even though there is no indication of permanent disability. The worker must be co-operating in a medical and/or vocational rehabilitation process and actively seeking employment.
3. Whose compensable condition limits activity to part-time employment.
4. Who suffers from an industrial disease requiring a change in employment, and the disease is not included or identified within "The Special Rehabilitation Assistance Programme to Remove Employees from the Hazards of Industrially Generated Diseases."
5. Whose usual employment could cause a recurrence or aggravation of the compensable condition.
6. Who has a compensable disability accompanied by a non-compensable disability.
7. Who, following a compensable condition with resultant physical limitations, has been successfully rehabilitated but, through redundancy of either skill or employment, requires further vocational rehabilitation assistance in locating suitable alternate employment.
8. Who has received a surplus cash settlement in connection with a Third Party Claim under Section 8(4) of the Act. Expenditure of benefits under Section 53 of the Act is not permitted while a surplus cash settlement remains.
9. Who resides in another province but in receiving benefits under the *Workers' Compensation Act* of Ontario. Vocational Rehabilitation Service is normally provided by other provincial boards and commissions in keeping with inter-provincial understanding.
10. Who relocates permanently from another province or territory to Ontario and at the request of and on approval from another provincial compensation board or commission in keeping with interprovincial understanding.
11. Exceptions to the preceding eligibility criteria will be considered on an individual basis.

## More Ineligibility Criteria

According to the *Claims Adjudication Branch Procedures Manual*, vocational rehabilitation services are not normally extended to a worker:

1. Who does not have an approved claim.
2. Who inflicts physical violence or who threatens physical violence on a board staff member.
3. Who resides outside Canada.
4. Who fails to accept suitable employment which is available and determined to be within the workers' interests, skills and capabilities and is considered to be realistic in terms of existing socioeconomic conditions.
5. Who has received extensive vocational rehabilitation service without benefit and where there is no evidence to indicate a change in response to counselling or a willingness to co-operate.
6. Who is medically capable of returning to usual occupation.
7. Who relinquishes employment of own volition without just cause.
8. Who has been terminated by the employer due to inappropriate conduct which is determined to be totally unrelated to the compensable condition.
9. Who lacks landed immigrant status, or a work permit.
10. Exceptions to the above will be considered on an individual basis.

If the injured worker is referred to the Vocational Rehabilitation Division they are again screened for eligibility by a rehabilitation services controller, within Vocational Rehabilitation Services. According to the *same* criteria used by the claims adjudicator. If they are deemed eligible by the rehabilitation services controller, the worker's file will be referred to a rehabilitation counsellor.

According to the WCB's overview of vocational rehabilitation services, injured workers may also request rehabilitation assistance at the head office. Preliminary vocational rehabilitation counsellors will provide counselling assistance for problems which can be resolved over a short period of time. If long-term involvement is necessary the worker will be referred to field rehabilitation counsellors.

## *Organization of the Vocational Rehabilitation Division*

The major operating components of the Vocational Rehabilitation Division of the Workers' Compensation Board are:

- Policy and Program Development
- Vocational Counselling Branch
- Rehabilitation Resources Branch
- Employment Services

### Policy and Program Development

This unit was established in 1985 and operates with a staff of 10. Its main functions are policy development, quality monitoring, program evaluation, rehabilitation research, staff training and development and library resources.

### Vocational Counselling Branch

The vocational counselling branch is responsible for providing field vocational rehabilitation services. It has a staff of 124, which operates from offices in nine major centres around Ontario.

### Rehabilitation Resources Branch

The Rehabilitation Resources Branch has three main functional areas: referrals and preliminary vocational counselling; specialized counselling for severe and long-term injury cases; and financial counselling for workers who request a commutation of their pension.

At the time of the study, the branch has a staff of 123 which operates from the head office in Toronto and the Downsview Rehabilitation Centre.

The referral work specified is handled by a centralized control unit made up of clerical workers known as **rehabilitation service controllers** who screen referrals from the Claims Adjudication Division for eligibility for Vocational Rehabilitation Services. This branch is also responsible for preliminary rehabilitation counselling.

Rehabilitation specialists also come under the auspices of this branch. They are responsible for the most severely disabled workers, including spinal cord or traumatic head injuries.

### Employment Services

The goal of the Employment Services Branch is to provide effective employment and placement services to injured workers.

To this end the branch provides the following services: job finding, placement assistance, worksite analysis and labour-management consultation.

## *Description of Counselling Staff*

Before proceeding with a demographic description of the counselling staff employed by the Vocational Rehabilitation Division of the Workers' Compensation Board, it is necessary to provide a brief outline of their varied roles and functions.

The title "rehabilitation counsellor" can be broken down into five positions: field rehabilitation counsellor; preliminary vocational rehabilitation counsellor (located at the Downsview Rehabilitation Centre); preliminary rehabilitation counsellor (in-office counsellor); commutations counsellor; and rehabilitation specialist. Placement and employment specialists might be added to this list as they do, at times, perform functions similar to those of a rehabilitation counsellor.

The core line staff position of the Vocational Rehabilitation Division is undoubtedly that of the field rehabilitation counsellor. All counsellors employed by the regional and area offices and the majority of counsellors employed through the central office in Toronto are field rehabilitation counsellors. As the title suggests, these counsellors usually service clients in their homes.

According to the job description, their core function (and all rehabilitation counsellors) is to "provide effective vocational rehabilitation service to injured workers where their disabilities delay their recovery and return to employment."

Field counsellors look for jobs for clients either with the accident or new employer and if such employment is impossible clients may be retrained, counselled towards financial self-sufficiency or have their service discontinued. Field counsellors also spend a half or a full day in the office carrying out administrative duties.

The second type of counsellor, the preliminary vocational rehabilitation counsellor (PVRC) is located at the Downsview Rehabilitation Centre. The PVRC is a member of a multidisciplinary team clinic which includes a staff physician, physiotherapist, occupational therapist and a remedial gymnast. These general clinics may also include a nurse, a social worker, a psychologist, a psychiatrist and a therapeutic recreationist.

The centre has seven specialized teams which manage specific client groups. The PVRC deals with clients who are undergoing assessment at the centre usually upon arrival and departure. Client contact with the division often ends once the client is discharged from the centre. However, the client may be referred by the PVRC to a field counsellor in Toronto, one of the regional offices or the area offices if continuing involvement is necessary.

The third category of counsellor is the preliminary rehabilitation counsellor (PRC), an in-office counsellor whose time is divided between conducting entitlement interviews for Vocational Rehabilitation Services, an out-of-province caseload and a PRC caseload. Generally, the PRC caseload consists of "job ready" clients, and therefore, PRCs do not purchase agency assessments and retraining programs to the same extent as field counsellors. PRCs are located at the central office in Toronto only.

Another type of counsellor is the financial or commutations counsellor who also works out of the Toronto office. His or her main functions are to evaluate requests for commutation or advance of pensions and to provide financial and vocational counselling to clients.

The fifth type of counsellor is the rehabilitation specialist, generally a longer-term employee who deals with specialized caseloads of specific injuries which are considered more serious than others, such as paraplegia or head injury. Often rehabilitation specialists are involved in counselling of a more intensive nature than are other counsellors. Like field counsellors, rehabilitation specialists meet with clients in their homes.

The main function of the employment specialist is to promote employment for injured workers as a group. Employment opportunities solicited by employment specialists are entered into a job bank for use by rehabilitation counselling staff.

The key role of the placement specialist is to assist in the job placement of persons who are having some difficulty re-entering the job market. The placement specialist carries a caseload while the employment specialist does not. Clients may be involved with a placement specialist at the same time they are seeing a rehabilitation counsellor.

Worksite analysts or ergonomists are a recent addition to the rehabilitation counselling staff. Their function is to provide information to employers which will enable them to design or redesign workstations to accommodate injured workers.

The demographic description is based on a response rate of 119 out of 193 staff (61.66%) who received a demographic and job information questionnaire as part of a larger study regarding job satisfaction, job motivation, empathy and job burnout. The numeric breakdown of total respondents by job title is as follows: 82 field rehabilitation counsellors from head office; regional and area offices; 10 preliminary vocational rehabilitation counsellors from Downsview; 4 preliminary rehabilitation counsellors; 6 commutations counsellors; 5 employment specialists; 5 placement specialists; 2 rehabilitation specialists; 2 worksite analysts and 3 employees who did not specify a job title and/or location on their questionnaires (see Table 4 for response rate by job title and region).

The response sample was comprised of a near even split between the sexes with 50.85% male and 49.15% female. The average age of the sample was 32.84 (standard deviation = 7.12). On average, field counsellors had been employed with the board, in some capacity or another for 4.81 years and all counselling staff for 5.73 years.

Employment specialists reported the highest average duration of service of 21.72 years and preliminary rehabilitation counsellors reported the lowest duration at 1.6 years. This finding is not surprising given that the preliminary counselling position is entry level and the specialist positions are the most senior of counselling versus administrative, positions for the Division.

Regarding education, 56.7% of the respondents indicated that they had a three-year or four-year bachelors degree; 17.8% had a community college certificate; 11% has both a bachelors and a community college certificate; 11.9% had a masters degree and 2.5% had a high school diploma.

The most common post-secondary degree was a bachelors or honours degree in psychology, with 25.4% majoring in psychology and another 9.4% who had taken psychology courses to fulfill part of their degree requirements. The second most common areas of concentration were sociology and social work, each 11% of the sample. Business-related degrees accounted for 8.5% of the sample and represented the third most frequent type of degree.

The remaining participants had a variety of different degrees ranging from rehabilitation certificates and kinesiology to fine art and languages (see Table 5 for a breakdown of level of education by area of concentration). In addition, 10% indicated that they were currently working on another degree or certificate.

Counselling staff also reported that 22% were currently or had in the past taken advantage of the board's tuition assistance plan. This plan specifies that the board will retroactively cover the cost of tuition for a job-related course once the course is successfully completed. In addition, 37% reported that they had taken courses on their own, either before or after hire at the board, which were related to their work.

The majority of staff reported that they had work experience which was related to their current job prior to being hired by the Board.

## Education of Counsellors

While it is recognized that almost any type of experience can be relevant depending on the individual, the research team decided to limit it to three basic categories of experience:

1. previous employment in a social service environment (includes volunteer, counselling and supervisory employment);
2. a background in education (often with adult learners);
3. industrial experience (usually employment in the same types of industries as injured workers). Seventy- seven percent of the counselling staff reported that they had previous experience related to their current position.

The demographic questionnaire also required that counselling staff list their facility in languages. In addition to English, staff reported that to varying degrees of competency they spoke the following languages: French (44%); Italian (8%); Portuguese (6%) and other languages (13%) (see Table 6 for a summary of languages facility).

### Table 4
## Profile for Questionnaire Respondents

| | Toronto & Vicinity (Ham., Osh. St. Cath. | Northern Ont. (Sud., N. Bay, T. Bay, Timmins Sault Ste. Marie) | Western Ont. (Ln., Wind., Kitch.) | Eastern Ont. (Ottawa, King.) | Central Ont. (Musk., Orr., Peter.) | Total Field |
|---|---|---|---|---|---|---|
| **Response Rate** | 45/74 | 11/22 | 12/19 | 8/9 | 6/6 | 82/130 |
| % Male Respondents | 46.70 | 63.64 | 41.66 | 62.50 | 50.00 | 50.00 |
| Ave. Years with Board | 4.51 | 5.53 | 7.30 | 2.35 | 4.63 | 4.81 |
| Ave. Years in Current Position | 3.18 | 5.07 | 4.55 | 2.15 | 3.40 | 3.52 |
| Ave. Current Caseload | 76.95 | 104.60 | 71.25 | 81.88 | 68.33 | 79.33 |
| Ave. Weekly Hours Worked | 46.07 | 52.09 | 46.42 | 46.88 | 52.5 | 47.63 |
| Ave. Percent Time Counselling | 32.78 | 30.80 | 39.58 | 26.88 | 36.67 | 33.21 |
| Ave. Percent Time Travelling | 19.93 | 19.44 | 16.36 | 15.00 | 24.17 | 19.45 |
| Ave. Percent Time Paperwork | 38.57 | 43.80 | 36.67 | 43.75 | 25.00 | 38.38 |

**Staff time estimates do not necessarily total 100%*

Regarding caseload size, field counsellors reported an average caseload size of 79.33, with Northern Ontario (Sudbury, North Bay, Thunder Bay, Sault Ste. Marie and Timmins) scoring highest at an average of 104.6 and Central Ontario (Muskoka, Orillia and Peterborough) scoring lowest with an average of 68.33 (see Table 4 for caseload size by job title and region).

Clearly, caseload size is high and certainly was the number one complaint voiced by field counsellors and other staff during 50 personal interviews of the counselling staff. Eighty–three percent of field counsellors stated that caseload sizes were very unreasonable or unreasonable, while 14% reported that they were reasonable or very reasonable. One person was neutral regarding caseload size. Many suggested a cap on size and the average caseload size which field counsellors felt to be manageable under existing conditions was 53. Several counsellors complained that they were reacting to emergencies rather than pro–actively helping clients to plan and solve problems, a complaint which is also voiced by injured workers.

The entire counselling staff estimates that they work an average of 46.63 hours per week with rehabilitation specialists reporting the highest number of hours worked at 55.0, closely followed by Central and Northern Ontario field counsellors at 52.5 and 52.09, respectively. Field counsellors and rehabilitation specialists are paid for a 40 hour work week while others are paid for a 36 1/4 hour work week. The sample also indicated that, on average, they spend 39.93% of their work week performing administrative duties or paperwork; 33.30% of their time counselling and 17.61% of their time travelling (see Table 4 for a breakdown of work week.)

Clearly, counsellors are estimating a very high percentage of time performing paperwork which is certainly not uncommon for public sector agencies of this sort (Howell, 1983). Surely, there are methods of reducing the volume of paperwork so that more time can be freed up for counselling and client contact, a change which the counsellors indicated to be highly desirable during their interviews

## Table 5

## Education of Questionnaire Respondents Area of Concentration

**Total = 118**

**Degree Received**

High School Only: 2.5% (3)

| | % Total | Psych. | Soc. | Psych./ Soc. | Psych./ Sci. | Soc. Work | Rehab. | Psych./ Soc. Work | Soc. Serv. | Hum. Kine-tics | Bus. Rel-ated | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Community College Only | 17.8 | 3 | | | | 1 | 4 | | 7 | | 5 | 1 |
| Bachelors Only | 38.1 | 10 | 7 | 6 | 2 | 8 | | | | 3 | 3 | 6 |
| Honours Bachelors Only | 18.6 | 9 | 3 | 2 | | 3 | | | | 2 | | 3 |
| Bachelors + Community College | 11.0 | 6 | 1 | 1 | | | | 1 | | | | 4 |
| Masters | 11.9 | | | | | | | | | | | |
| % of Total | | 25.4 | 11.0 | 7.6 | 1.7 | 11.0 | 3.4 | .08 | 5.9 | 5.1 | 8.5 | 17.0 |

## Table 6

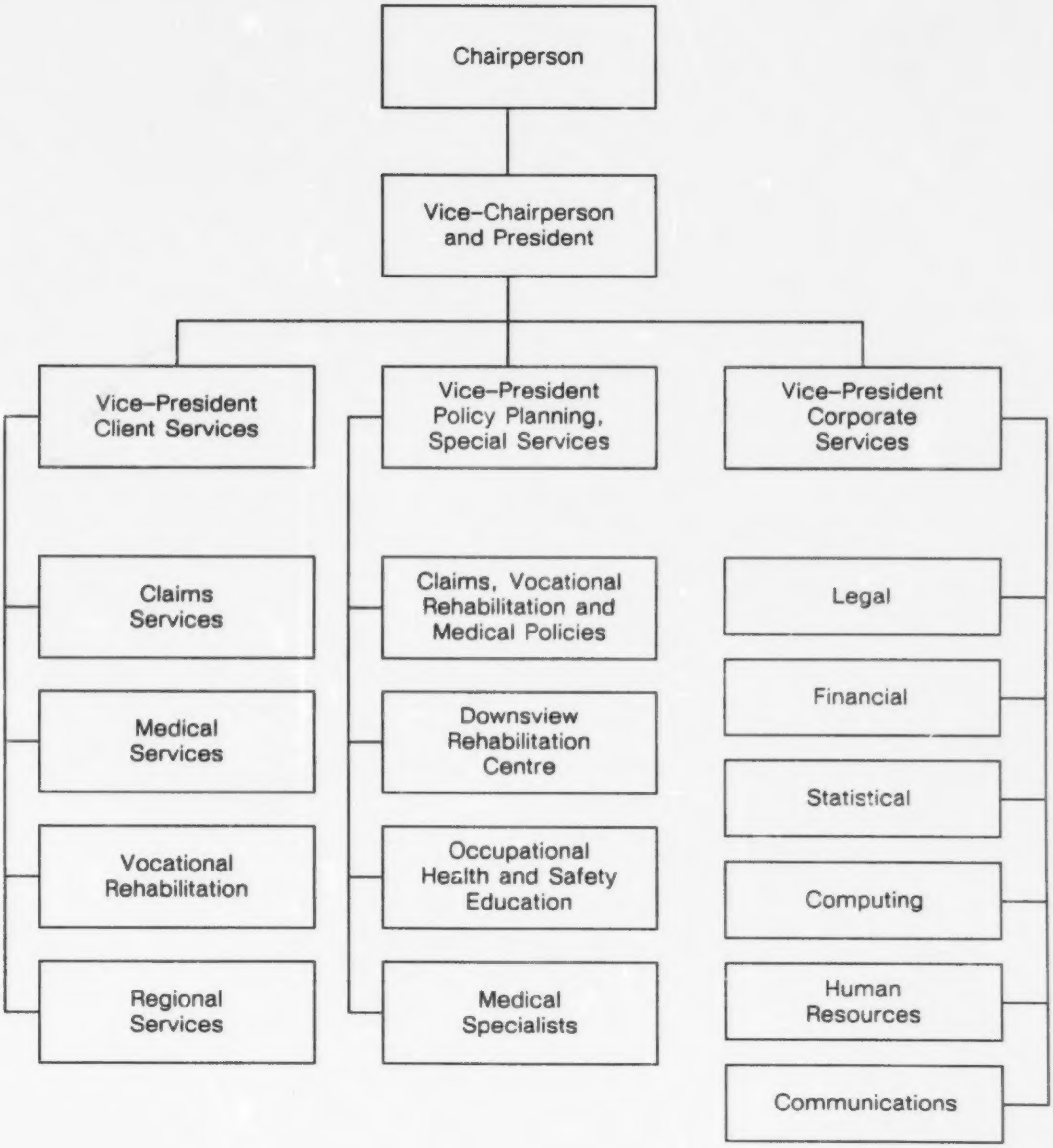
## Languages Spoken and Written By Counselling Staff

*(Other than English)*

**Total = 118**

| Language | | Number | Percent of Total |
|---|---|---|---|
| French | Spoken | 52 | 44 |
| | Written | 51 | 43 |
| Italian | Spoken | 9 | 8 |
| | Written | 9 | 8 |
| Portugese | Spoken | 7 | 6 |
| | Written | 6 | 5 |
| Other | Spoken | 15 | 13 |
| | Written | 15 | 13 |

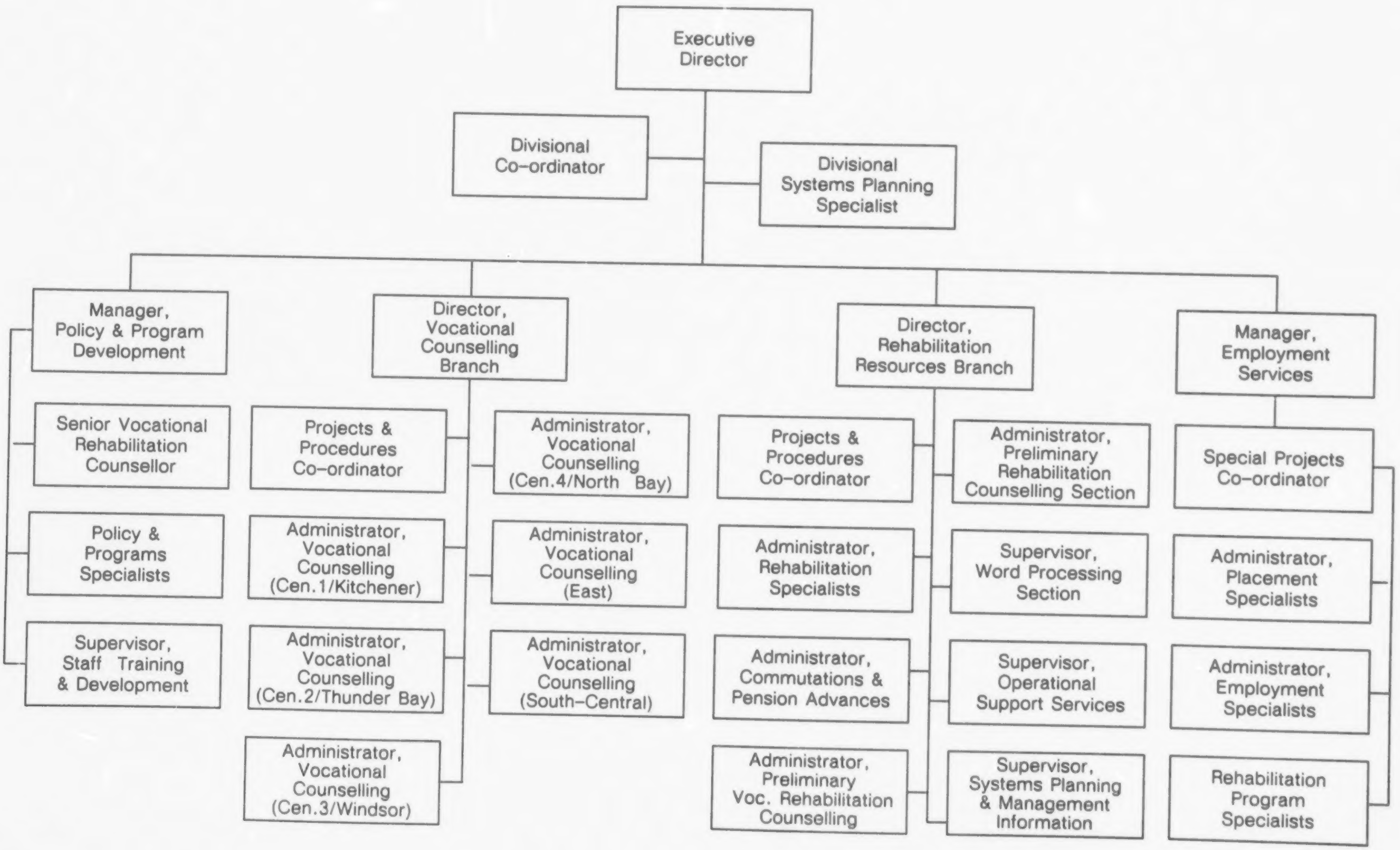
**Organizational Chart**
**Workers' Compensation Board**


Chairperson
Vice-Chairperson and President
Vice-President Client Services
Vice-President Policy Planning, Special Services
Vice-President Corporate Services
Claims Services
Medical Services
Vocational Rehabilitation
Regional Services
Claims, Vocational Rehabilitation and Medical Policies
Downsview Rehabilitation Centre
Occupational Health and Safety Education
Medical Specialists
Legal
Financial
Statistical
Computing
Human Resources
Communications

Source: *Rapport,* Vol. 9, No. 2, 1986, pp. 1–2.

## Organization of Vocational Rehabilitation Division, WCB

*(December 1985)*



Executive Director
Divisional Co-ordinator
Divisional Systems Planning Specialist
Manager, Policy & Program Development
Senior Vocational Rehabilitation Counsellor
Policy & Programs Specialists
Supervisor, Staff Training & Development
Director, Vocational Counselling Branch
Projects & Procedures Co-ordinator
Administrator, Vocational Counselling (Cen.1/Kitchener)
Administrator, Vocational Counselling (Cen.2/Thunder Bay)
Administrator, Vocational Counselling (Cen.3/Windsor)
Administrator, Vocational Counselling (Cen.4/North Bay)
Administrator, Vocational Counselling (East)
Administrator, Vocational Counselling (South-Central)
Director, Rehabilitation Resources Branch
Projects & Procedures Co-ordinator
Administrator, Rehabilitation Specialists
Administrator, Commutations & Pension Advances
Administrator, Preliminary Voc. Rehabilitation Counselling
Administrator, Preliminary Rehabilitation Counselling Section
Supervisor, Word Processing Section
Supervisor, Operational Support Services
Supervisor, Systems Planning & Management Information
Manager, Employment Services
Special Projects Co-ordinator
Administrator, Placement Specialists
Administrator, Employment Specialists
Rehabilitation Program Specialists

# Glossary

**Assessment, Functional**: The measurement of abilities and limitations in a number of areas, including mobility, communications, sensory and motivity and any other areas related to life adjustment.

**Assessment, Medical**: This is an examination by a physician and/or a designate to ascertain the degree of impairment of an individual.

**Assessment, Vocational**: The evaluation of the vocational potential of an individual, usually performed by individuals with psychometric skills such as psychologists or occupational therapists.

**Assessment, Work**: The evaluation of strengths and weaknesses of an individual to determine appropriate work placement. The assessment is usually carried out in community-based centres, or in sector based centres.

**Case Management**: A method of providing comprehensive, unified, co-ordinated and timely services to people in need of them through the efforts of a primary agent, who, together with the client, takes responsibility for providing or procuring the services needed.

**Caseload, Hidden**: Injured workers who could benefit from the receipt of the full range of rehabilitation services but have not received them either because they were not referred or because they were denied the services.

**Community-Based Centre**: A centre in the community, usually including a rehabilitation workshop, that offers work assessment and work adjustment training to people with disabilities. Most centres are in the private sector and sponsored by community funds.

**Compensation**: A generic term including all financial benefits available to the injured worker, including topping off wages and pensions.

**Counsellor, Intake**: A counsellor employed by the Rehabilitation Division of the Workers' Compensation and Rehabilitation Board whose functions are:

- to receive referrals for rehabilitation services from claims adjudicators, physicians and injured workers
- to assess the need for involvement by the rehabilitation services and monitor the progress of acute health care
- to assign cases to case managers

**Counsellor, Rehabilitation**: A professional in the Rehabilitation Services Division trained in counselling skills who is able to perform the following duties:

- to effectively organize and co-ordinate a system whereby individual clients are provided services that will lead to economic independence and an acceptable level of quality of life and dignity,
- to supply crisis counselling services, where necessary,
- to determine the need for, and to purchase rehabilitation services, as required,
- to effect a smooth, rapid and effective flow of cases and services, with maximum return from purchased services that will be utilized in restoring clients to the most independent status of which they are capable,
- to seek feedback from clients regarding the quality of service offered,
- to follow up clients for one year after closing a case.

**Disability**: Any restriction or lack of ability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being.

**Employment Resources Specialist**: A professional in the Rehabilitation Services Division with knowledge and experience in the work world, who is able to perform the following duties:

- to advise the case manager in all things relating to vocational and employment rehabilitation
- to obtain job listings by good communications with employers

- to match jobs to injured workers
- to find placement positions for injured workers

**Handicap**: A disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual.

**Impairment**:Any loss or abnormality of psychological, physiological, or anatomical structure or function.

**Injured Worker**:A worker who has suffered a disability because of an accident at the workplace or because of contracting an occupational disease.

**Injury, Invisible**:A disability that is not readily apparent to the observer and whose assessment is largely subjective. Includes such things as chronic back pain, muscle strains and sprains such as tendonitis — a carpel tunnel post–traumatic stress disorder — and depression.

**Injury, Serious**: An injury caused to a worker which keeps him or her from returning to employment within 30 days.

**Injury, Visible**: A disability that is apparent and can be assessed with objective medical procedures. Visible injuries include such things as lacerations, bone fractures, or amputated limbs.

**Job Modification**: A variety of alternatives to a job or worksite, carried out in order to provide suitable work for injured workers to permit them to participate in the work place and utilize their abilities. The alternatives may include the following:

- designing more flexible worksite layouts
- rescheduling work hours
- reassigning non–essential job duties to others
- acquiring technical aids
- providing new or modified tools

**Physiatrist**: A physician who specializes in that branch of medicine, sometimes known as physical medicine, that is concerned with the diagnosis, treatment and prevention of disease with the aid of physical agents. Physiatrists are also concerned with medical rehabilitation of people with physical disabilities.

**Rehabilitation**: The restoration of workers who have suffered occupational injuries or debilitating diseases linked to the workplace to the fullest physical, mental, social and vocational and economic usefulness to the maximum possible extent.

**Rehabilitation, Functional**: The assessment of the physical impairment resulting from a work injury and its reduction to the maximum possible extent.

**Rehabilitation, Psychosocial**: The assessment of psychological and social handicaps resulting from a work injury and their reduction to the maximum possible extent.

**Rehabilitation, Vocational**: The assessment of the vocational potential of a worker injured on the job and the development of a program that will remove employment barriers, taking into account the realities of both the injured worker's area of strength and limitation and the demands of the current competitive employment market.

**Rehabilitation, Work**: The evaluation of the work potential of a person injured in the workplace and the strengthening of the worker's work habits and work skills, usually at a job site or a simulated work shop.

**Sector–Based Centre**: A centre in the community, that provides work assessment and work adjustment training to injured workers in affiliation with an industrial or construction sector in the community. The services provided may be located in the industry itself or in the near vicinity and be supervised by staff of the industry. Management of the centre may be representative of the industry and of labour.

## Appendix A

# List of Hearings Held Throughout the Province

| | |
|---|---|
| October 20, 1986 | Thunder Bay |
| October 21, 1986 | Sault Ste. Marie |
| October 22, 1986 | Timmins, Elliott Lake |
| October 23, 24, 1986 | Sudbury |
| November 3, 1986 | Kitchener/Waterloo |
| November 4, 1986 | London |
| November 5, 1986 | Sarnia |
| November 6, 1986 | Windsor |
| November 12, 1986 | First Portuguese Canadian Cultural Club, Toronto |
| November 17, 1986 | Ottawa |
| November 18, 1986 | Kingston |
| November 19, 1986 | Peterborough |
| December 1, 1986 | Oshawa |
| December 2, 1986 | St. Catharines |
| December 3, 1986 | Hamilton |
| December 8, 1986 | Scarborough |
| December 9, 10, 1986 | Toronto |
| December 10, 1986 | Columbus Centre, Toronto |
| December 11, 1986 | North York |
| December 12, 1986 | Mississauga |

# Appendix B

# Presentations at Public Meetings

Abbs, Jim

Abrams, Dorothy

Adams, Arnold

Addiction Research Foundation

Albert, Danny

Algoma Community Legal Clinic

Algoma Steel Corporation Limited

Alguire, Bob

Amalgamated Transit Union

Arklie, John G.

Arnold, Barbara

Arnold, Nicole

Asselin, Beatrice

Bagnulo, Romano

Baker, Roxie

Bakery, Confectionery and Tobacco Workers' International Union, Local 323T

Banjk Mr.

Barry, Doug

Beaulieu, Cyrille

Bechard, John

Beddard, Arthur

Behavioural Health Clinic

Bellmore, Keith

Benin, Marie

Bilotta, Christopher

Black, Peter

Blane, Louise

Blane, Sharon

Bocskei, Ron

Borcelino, Ignazio

Borland, Robert

Bristow, Gayle

Brooks, Ken

Brossean, Dr. Michel

Brunshaw, Gerry

Buchanan, Mr.

Burton, Jackie

Canadian Auto Workers, Locals 27, 80, 199, 200, 222, 303, 397, 444, 456, 636, 707, 1054, 1075, 1132, 1325, 1451, 1520, 1524, 1566, 1917, 1973 and 2163

Canadian Manufacturers Association

Canadian National Institute for the Blind

Canadian Paperworkers Union, Local 67, 79, 212

Canadian Union of Public Employees Ontario Division, Locals 79, 503, 1000 and 1750

Carraro, Giuseppe

Carlos, Roy

Cassidy, Peter

Cauchi, Eddie

Central Toronto Community Legal Clinic

Chauvin, Tom, Jr.

Cheel, Dennis

City of Hamilton

City of Windsor

Cizinoski, Stan

Clark, Joseph

Clark, Maureen

Clarke, Robert

Clement, Mr.

Clement, Robert

Cleroux, A.

Coalition for Public Transit Reduced Fare Program

Compensation Consulting Limited

Confederation College of Applied Arts and Technology (Thunder Bay)

COSTI-IIAS

Costonta, Tony

Council of Ontario Construction Associations

Cousineau, Robert

Cribbin, Jim

Crkvenac, Michael

Curry, Lillian

DaCosta, Louisa
Dalessandro, Luciano
Dean, Wally
Dellatarre, Lilian
DeMerchant, Ostin
Denison Mines Limited
Deschenes, Normand
Dicy, Wayne
Dimmer, Marlene
Donjhancic, Mario
Dooley, Michael
DosSantos, Mrs.
Douglas, Ron
Doxtater, Lorena
Dr. John Racinskas
Drew, Maureen
Drew, Syndey
Drummond, Jack
Duckworth, Mr.
Duggan, Teri
Dunsmore, Lynn
Durlago, Lyle
Duvnjak, Steve
Dwyer, Mike
Edwards, Ernest
Electricians Union
Elkinton, Bill
Empey, Fred
Energy and Chemical Workers' Union
Erskine, John
Everding, Fred
Falconbridge Limited (Sudbury Operations)
Fargoso, John
Ferreita, Francisco
Fex, Ron
Fisher Gauge Ltd.
Fleschner, Wayne
Francesco, Daquilanti
Franco, Robert
Freitas, Antonio
Fuller, Bill
Gilmour, Norm
Gioisa, Rosa
Godfrey, Dr. Charles W.
Gonsalves, Manual
Goodhall, Dave
Gooding, Ron
Gordon, Clive
Gosselin, Robert
Graham, Douglas
Great Lakes Association
Great Lakes Forest Products Ltd.
Green, Donald
Greene, Joan
Griffin, Steve
Hack, Richard
Haladzuk, Bill
Hall, Gerry
Hamer, Royce
Harris, Raymond
Hay, Carolyn
Hennessy, Mickey, MPP
Hill, Joanne
Howe, Ronald A.
Hudon, Gaetan
INCO, Ontario Division
Industrial Accident Victims Group of Ontario
Injured Workers Centre, Thunder Bay
Injured Workers Consultants
International Association of Bridge, Structural and Ornamental Ironworkers, Local 721
Jackson, Debbie E.
Jarvi, Reino
Jewish Vocational Services
Jhancic, Don

John, Gregory
Jordao, Lucidio
Joudrey, Michael
Kehoe, Mr.
Khan, Camaral
King, Garfield
Kinna–Aweya Legal Clinic
Kitchener Chamber of Commerce
Kitchener–Waterloo Injured Workers Group
Labourers International Union of North,America, Ontario Provincial District Council, Locals 183 and 247
Laronde, Dillon
Laughren, Floyd, MPP
Lauzon, Pat
Lauzon, Roger
Leoti, Benito
Lloyd, Larry
London and St. Thomas District Labour Council
Lopaso, Adriano
Lucier, Dan
MacDonnell, Mark
Maderos, Moniz
Mallory, Cheryl
Malone, Judith
March of Dimes
Marko, Mike
Marinaro, Lou
Martel, Elie, MPP
Masuka, Victorio
Matiation, Robert
Mauro, Antonio
McDonald, Gary
McGuire, Avis
McGuire, Henry
McKae, Floyd
McRae, Larry
Miller, Carol
Mills, Gary
Milmine, Don
Mohawk College (Hamilton)
Monte, Maria
Montoni, Donna
Moore, Hazel
Moreia, Jose
Moroun, Elmer Jr.
Morrow, Steven
Motor Vehicle Manufacturers' Association
Munuel, Larry
Murray, William
National Automobile and Agricultural Implement Workers Union of Canada
Naves, Mannal
New Democratic Party Provincial Caucus
Niagara North Community Legal Assistance
Noel, Rod
Novais, Francisco
Office of the Worker Advisor
Ontario Chiropractor Association
Ontario Federation of Agriculture
Ontario Federation of Labour
Ontario Hydro, Health and Safety Division
Ontario Hydro Employees, CUPE 1000
Ontario Legislative Committee of Canadian Railway Labourers Association
Ontario March of Dimes
Ontario Massage Therapy Association
Ontario Medical Board, Committee on Rehabilitation
Ontario Mining Association
Ontario Nurses' Association
Ontario Physiotherapy Association
Ontario Public Service Employee Union
Orban, John
Pacifico, Carmen

Palazzolo, Biagio
Papascioti, Giovanni
Parkdale Community Legal Services
Parker, Gerald
Peel Union of Injured Workers
Perdias, Mr.
Petitti, Vince
Petrocelli, Dominic
Phillips, Gary
Pileggi, Toto
Plastics, Rose
Poole, Susan M.
Porcupine Mine Managers Group (Detour Lake, Dome, Kidd Creek, Pamour and Steetly Talc.)
Portuguese Interagency Network
Provincial Building and Construction Trades Council of Ontario
Quaker Oats
Quinte and District Injured Workers' Group
Racinskas, Dr. John
Raftis, Don
Raftis, John
Rauol, Fortinato
Rehabilitation Services of Canada
Reiber, Joanne
Reid, James
Reid, Peter
Reilly, Eamon
Retail Council of Canada
Rhodes, Peter (Constituency Assistantto Peter Peterson, MP)
Richer, Leonard
Rimmer, Phil
Rio Algom Limited, Guy Napier
Robertson, Grant
Robino, Dominic
Rolfe, Basil
Ronald, Douglas
Ronko, Maria
Roscoe, George
Rose Plastics
Rowland, Richard
Roy, Marcel
Royal Ottawa Regional Rehabilitation Centre
Rud, Peter
Rumble, Dorothy
Rutledge, Boyd
Safety Compensation Consulting Ltd.
Santerre, Rene
Santos, Joaquim
Schimiczer, Horst
Schincariol, Olivia
Scott, Edward
Sears, Milton
Sergio, Mr.
Serowski, Ray
Service Employees International Union
Setembrezi, Theresa
Shidyoni, Nano
Silva, Martin
Spencer, Clarence
Spina, Francesco
Stewart, Don
Stoker, Gerry
Stringer, Norman
Struthers, Darcy
Sudbury and District Labour Council
Sudbury Mine, Mill and Smelter Workers Union, Local 598
Sumbonia, Maria
Swan, Joe
Switzer, Dennis
Tancredi, Mr.
Teresianski, Joan
Tessier, Gaetan
Travis, John

Tremblay, Richard

Tucci, Nick

Turner, Mrs.

Ublansky, Daniel

Union of Injured Workers: Southwestern, Toronto, Sudbury, Peel, Sarnia

Union of Injured Workers Legal Clinic

United Brotherhood of Carpenters and Joiners of America, Lake Ontario District Council

United Food and Commercial Workers International Union

United Paper Workers

United Steelworkers of America, District 6, Locals 1005, 4440, 5328, 5417, 5599, 6500, 7135, 7580, 8895 and 13911

United Steelworkers of America, Toronto Area Council

United Transportation Union

Valiquette, Albert

Valiquette, Maurice

VanKooten, Andrew

VanVeggel, Joe

Vedo Construction

Victoria Hospital, London

Vincent, Darlene

Wallace, Doug

Washington, Gordon

Waterloo Region Community Legal Services

Wemple, Les

William D. Griffith and Associates

Williams, Fuller

Williams, Ken

Wood, Bruce

Woodfield, Mrs.

Wouters, Gaetan

Zylstra, Peter

## Additional Written Submissions

Abitibi–Price

Acierro, D.

Amity Goodwill Industries Hamilton

Board of Directors of Physiotherapy

Cambrian College

Cambrian Memorial Hospital

Canadian Auto Workers Workers Compensation Committee

Canadian National Railways Co. Ltd

Canadian Pacific

Canadian Railway Labour Association

Chedoke–McMaster Hospitals

Clory, Joseph

Consultants

D'Andreis, Pam

Dome Mines Limited

Dow Chemical Canada Inc.

Employee Assistance Association of Toronto

Employment/Education Training Programme Sault. Ste. Marie

Fanshaw Injured Students Together

Farm Safety Association

Flemingdon Community Legal Services

Goodwill Industries of Toronto

Gordon, James MPP

Group Health Centre

Hamilton–Wentworth, The Regional Municipality of

Head Injury Association

Hill, Wade

Kapuskasing, Corporation of the Town of

Kauth, Fran

Kidd Creek Mines Limited

Kingston General Hospital, Department of Vocational Services

Kitchener–Waterloo Hospital, Employee Health Services

Kitchener–Waterloo Occupational Therapy

Klachn, L.

Knechtel, K.

Laurentian Hospital

Legal Assistance Kent

London Goodwill Industries Association

Mazmanian, C.

Ministry of Community and Social Services

Mount Sinai Hospital

Niagara On The Lake General Hospital

Nippissing Community Legal Clinic

Ontario Chamber of Commerce

Ontario Occupational Health Nurses Association

Ontario Pharmacists Association

Ontario Psychological Association

Orthopaedic & Arthritic Association

Phillips, Lyall

Piccinetti, Yvonne

Saint Catherines Screw Machine Products Limited

Saint Joseph's General Hospital

Saint–Vincent Hospital

Sarnia, City of

Scarborough, City of and Local 368

Seven Arrows Learning Centre

Sioux Lookout Community Legal Clinic

Sudbury, The Corporation of the City of

Sukhjit, Gill

Szalai, S.

Thunder Bay and District Injured Workers Support Group

Thunder Bay and District Labour Council

Timmins Chamber of Commerce

Toronto Caseworkers Working Group

Toronto–Central Ontario Building & Construction Trades Council

Tremblay, Denis R.

United, Rubber Cork, Linoleum and Plastic Workers, Local 113

United Steelworkers of America, Local 14873

United Steelworkers of America, Steelworkers Toronto Area Council

Weatherall, Phil

Welsh Chiropractic Clinic

West Park Hospital

Wood Lynn Farms Limited

Workers Compensation Appeals Tribunal (Gary Newhouse)

## Appendix C

# Synopses of Reports and Studies Submitted

Boschen, Dr. Kathryn A., *Early Intervention in Vocational Rehabilitation: A Review of the Literature*, November 1986.

This study reviews the existing literature on research into early intervention with rehabilitation clients. Little actual empirical research has been performed in the area of early intervention in the rehabilitation of injured workers, although many articles testify to its importance. Ten typical reasons cited for early intervention are listed. A review of the theoretical literature relating to the process of adjustment to significant negative life events is provided and supports the proposition of the benefits of early intervention. Stage theories of adjustment indicate that a theoretically optimal time for intervention exists. The report also examines the role of the private rehabilitation industry in early intervention and identifies the strengths of this approach and American and Canadian information on the topic. Finally, the report describes an American early intervention program of preventative rehabilitation.

Chambers, Julie and Day, Dr. Hy, *Job Satisfaction and Job Attitudes: A Study of Counselling Staff Employed by the Vocational Rehabilitation Division of the Workers' Compensation Board*, June 1987.

This study, commissioned by the Task Force, examines job satisfaction, job attitudes and role perceptions in service delivery among counselling staff of the Vocational rehabilitation staff of the Workers' Compensation Board. Information was gathered through standardized questionnaires and semi–structured interviews. Counsellors reported less job satisfaction, more empathy and less personal distress than a comparison group. Vocational rehabilitation counselling staff also find their work less interesting than a comparable sample of rehabilitation counsellors. Although a substantial proportion scored high on the burnout scale, on average they did not indicate high levels of burnout. Caseload size is negatively related to job satisfaction and intrinsic motivation and positively related to burnout. The proportion of work time actually spent counselling is positively related to job satisfaction and intrinsic motivation and negatively related to burnout. The main concern expressed by counsellors was the volume of work and its impact on service delivery. Communications were also perceived to be a problem. Concern was expressed over the focus of performance appraisals, which were perceived to have an undue emphasis on quantity rather than quality of service. Counsellors were generally positive regarding supervisory support, although they expressed a desire for greater participation in divisional policy making.

Feurwerker, Dr. Emmanual, *A Study on Re–Employment, Retraining and Relocation*, June 1987

This study identifies existing rules and regulations regarding re–employment, retraining and relocation of workers who have suffered a work–related accident or illness in Quebec, France and West Germany. The practice and application of these regulations is reviewed with supporting data and statistics, where available.

Hitner Starr Associates, *Strategies to Overcome Barriers to the Employment of Injured Workers in Ontario*, June 1987.

This report addresses issues pertaining to the re–employment of injured workers in Ontario who are clients of the Vocational Rehabilitation Division of the Workers' Compensation Board. The report analyzes statistical data on VRS outcomes and options for employers to overcome re–entry barriers for disabled workers. Labour market conditions which affect the rehabilitation of injured workers are also examined. Other factors investigated include the social and physical barriers to re–employment and the role of organized labour in this process. Lastly, the report explores the statutes and regulations which provide the framework for the vocational rehabilitation system.

Institute of Northern Research and Development, *Report on Survey of Information for a Vocational Rehabilitation Program for Northern Ontario*, May 1987.

This survey reports on the desirability and feasibility of creating centres for the rehabilitation of injured workers in Sudbury and Thunder Bay. The principal areas of research included: the availability of adequate medical and para-medical support; transport and communication; and the demographic profile of Northern Ontario. The report concludes that it would both improve the quality of service and be cost effective to establish two regional centres for the rehabilitation of injured workers.

Koepfler, Louise E., Mainwaring, Lynda M. and Day, Dr. Hy, *Injured Workers' Perceptions of Vocational Rehabilitation and the Workers' Compensation Board of Ontario*, June 1987.

This study sampled opinions and experiences of injured workers to ascertain level of satisfaction with the Vocational Rehabilitation Division of the Workers' Compensation Board and to isolate factors which might affect perceptions of service. One hundred and twenty randomly selected injured workers were questioned on six topic areas: 1) demographic information; 2) details of the injury and the socioemotional impact of the injury on the worker and family; 3) experiences with WCB and VRD; 4) experiences with the Downsview Rehabilitation Centre; 5) present employment and employment goals; and 6) general life satisfaction.

Koepfler, Louise E. and Day, Dr. Hy, *Purchase of Service Study*, May 1987.

This study examines survey data collected from agencies which provide services that may be purchased by the Vocational Rehabilitation Division of the Workers' Compensation Board. The survey attempted to make comparisons between those agencies which receive VRS clients and those that do not. It was found that agencies which receive VRS clients do not differ markedly from agencies which do not, in terms of services provided. Agencies receiving VRS clients do differ in that they tend to be larger, high-profile organizations which regularly charge a fee for service, have shorter waiting list durations and more short-term training programs. The agencies were satisfied with their relationship with VRS despite some problems with referral information. Agencies were also positive about the compatibility of their services with VRS and the use of their reports in decision making about VRS clients. VRS clients appear to be functionally equivalent but psychologically more distressed in comparison with the agencies' other clients.

Mainwaring, Lynda M. and Day, Dr. Hy, *Vocational Rehabilitation Services: An International Review*, June 1987.

This study was commissioned to examine models of vocational rehabilitation services provided in other jurisdictions. Programs from eight provincial boards, three provincial agencies, four American boards, one state VRS and five other western countries were examined. Each model was examined in terms of: the definition of rehabilitation; VR program objectives; mandatory rehabilitation; referrals to rehabilitation; case management; counsellor education; the link between compensation and rehabilitation; employment options for the disabled, and reinstatement of injured workers to their pre-injury employer.

Native/Canadian Relations Theme Area, *Workers' Compensation Board and the Indian Community in Ontario*, May 1987.

This study was commissioned to provide insight into the relationship between the WCB and the Native Community and to identify problems and measures to correct the situation. The study included: a demographic overview consisting of statistical data on registered Indians in Ontario, the Registered Indian labour force and the health of Native people in Ontario, as well as literature on the living conditions of Native people, health care delivery and modes of work and working conditions of Native Canadians. A review of Workers' Compensation claims filed from Ontario reserves was also undertaken which revealed that the workforce bias of the WCB disqualifies a significant proportion of Native work activities. In addition, many Bands knew very little about the WCB or its programs and services, including vocational rehabilitation. Premium costs were frequently too expensive for many bands.

Yalnizyan, Armine, *Retraining and Vocational Rehabilitation of Injured Workers*, May 1987.

This study was commissioned by the Task Force to examine the training needs of injured workers and the adequacy of the services provided by the Vocational Rehabilitation Division. It examines the provision of services in terms of access and eligibility and the types of programs available. This is followed by an analysis of the demand for service in terms of the age, gender, language and injury profile of injured workers. A "bill of rights" for injured workers is outlined, as well as other remedial measures for the existing system. Finally, alternative models of service delivery are discussed.

## Appendix D

# Northern Tables

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### Table 1

## Active Treatment Beds (Northern Ontario) by Region, District, Municipality, Expressed as a Ratio to the Population Northwest Region

**Kenora/Rainy River District**

| Municipality | Population* | Active Beds | Beds Per $10^3$ |
|---|---|---|---|
| Atikokan | | 25 | |
| Dryden | | 68 | |
| Fort Frances | | 117 | |
| Kenora | | 148 | |
| Rainy River | | 15 | |
| Red Lake | | 44 | |
| Sioux Lookout | | 86 | |
| | **76,351** | **503** | **6.6** |

**Thunder Bay District**

| Municipality | Population* | Active Beds | Beds Per $10^3$ |
|---|---|---|---|
| Geraldton | | 41 | |
| Hogarth | | 344 | |
| Manitouwadge | | 28 | |
| Marathon | | 25 | |
| Mckellar | | 312 | |
| Nipigon | | 33 | |
| Terrace Bay | | 23 | |
| Thunder Bay | | 389 | |
| | **154,449** | **1,195** | **7.7** |
| **Northwest Region** | **230,800** | **1,698** | **7.4** |

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* *Statistics Canada, 1986 Census (Interim Counts)*

### Table 2

## Active Treatment Beds (Northern Ontario) by Region, District Municipality, Expressed as a Ratio to the Population Northeast Region

**Algoma District**

| Municipality | Population* | Active Beds | Beds Per $10^3$ |
|---|---|---|---|
| Elliot Lake | | 144 | |
| Blind River | | 50 | |
| Thessalon | | 17 | |
| Sault Ste. Marie | | 254 | |
| Plummer | | 261 | |
| Wawa | | 38 | |
| Horne Payne | | 16 | |
| | 130,820 | 780 | 5.9 |

**Cochrane District**

| Municipality | Population* | Active Beds | Beds Per $10^3$ |
|---|---|---|---|
| Cochrane | | 60 | |
| Hearst | | 70 | |
| Iroquois Falls | | 40 | |
| Kapuskasing | | 82 | |
| Matheson | | 24 | |
| Moose Factory | | 74 | |
| Moosonee | | 35 | |
| Porcupine | | 66 | |
| Smooth Rock Falls | | 19 | |
| South Porcupine | | 104 | |
| Timmins | | 184 | |
| | 92,983 | 758 | 8.2 |

**Nipissing District**

| Municipality | Population* | Active Beds | Beds Per $10^3$ |
|---|---|---|---|
| Mattawa | | 30 | |
| Nipissing | | 89 | |
| North Bay | | 364 | |
| | 78,277 | 483 | 6.2 |

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**Table 2 (Cont'd.)**

**Parry Sound District**

| **Municipality** | **Population*** | **Active Beds** | **Beds Per $10^3$** |
|---|---|---|---|
| Parry Sound | **33,521** | **92** | **2.7** |

**Sudbury/Manitoulin District**

| **Municipality** | **Population*** | **Active Beds** | **Beds Per $10^3$** |
|---|---|---|---|
| Espanola | | 32 | |
| Chapleau | | 30 | |
| Little Current | | 75 | |
| Sudbury | | 865 | |
| | **186,861** | **1,002** | **5.4** |

**Timiskaming District**

| **Municipality** | **Population*** | **Active Beds** | **Beds Per $10^3$** |
|---|---|---|---|
| Englehart | | 35 | |
| Kirkland Lake | | 132 | |
| New Liskeard | | 135 | |
| | **39,956** | **302** | **7.6** |
| **Northeastern Region** | **562,418** | **3,417** | **6.1** |

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* *Statistics Canada, 1986 Census (Interim Counts)*

Table 3

### Active Hospital Beds (Northern Ontario) Rate per 1,000 of the Population by Region

| Region | Population* | Beds | Rate Per $10^3$ |
|---|---|---|---|
| Northwest Region | 230,800 | 1,698 | 7.4 |
| Northeast Region | 562,418 | 3,417 | 6.1 |
| | **793,218** | **5,115** | **6.4** |

Ontario: Average Provincial Rate – Beds per $10^3$ = 5.7 beds

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* *Statistics Canada, 1986 Census (Interim Counts)*

### Table 4

## Presence/Absence of Rehabilitation Services by Region, District and Municipality Northwest Region

| Kenora/Rainy River District | Physio-Therapy Dept. | Staff F.T.E.* | Occupational-Therapy Dept. | Staff F.T.E.* | Psych Services Dept. | Available Beds ** |
|---|---|---|---|---|---|---|
| **Municipality** | | | | | | |
| Atikokan | Yes | 2.0 | No | 0 | No | 0 |
| Dryden | Yes | 3.0 | Yes | 1 | No | 0 |
| Fort Francis | Yes | 3.0 | No | 0 | No | 0 |
| Kenora | Yes | 5.5 | Yes | 0 | Yes | 20 |
| Rainy River | No | 0 | Yes | 1 | No | 0 |
| Red Lake | Yes | 2.0 | Yes | 0 | No | 0 |
| Sioux Lookout | Yes | 1.5 | Yes | 0 | No | 0 |
| **Thunder Bay District** | | | | | | |
| **Municipality** | | | | | | |
| Geraldton | Yes | 2.5 | No | 0 | No | |
| Hogarth | Yes | 5.0 | No | 0 | No | |
| Manitouwadge | Yes | 1.0 | No | 0 | No | |
| Marathon | Yes | 1.0 | No | 0 | No | |
| Mckellar | Yes | 8.0 | Yes | 3.5 | Yes | 24 |
| Nipigon | Yes | 2.0 | No | 0 | No | |
| Terrace Bay | Yes | 2.0 | No | 0 | No | |
| Thunder Bay | Yes | 15.0 | Yes | 36.7 | Yes | 237 |

*F.T.E. *Full-time Equivalent is the funding equivalent allocated. It is sometimes exceeding but more often unmatched in reality.*

** *"Psychiatric Services hospital beds available" the total beds devoted to psychiatric services within general hospitals as well as beds in psychiatric institutions.*

### Table 5

## Presence/Absence Of Rehabilitation Services by Region, District and Municipality Northeast Region

| **Algoma District** | **Physio-Therapy Dept.** | **Staff F.T.E.*** | **Occupational-Therapy Dept.** | **Staff F.T.E.*** | **Psych. Services Dept.** | **Available Beds **** |
|---|---|---|---|---|---|---|
| **Municipality** | | | | | | |
| Elliot Lake | Yes | 2.0 | No | 0 | No | 0 |
| Blind River | Yes | 1.0 | No | 0 | No | 0 |
| Thessalon | No | 0.0 | No | 0 | No | 0 |
| Sault Ste. Marie | Yes | 7.0 | Yes | 2.2 | | |
| Plummer | Yes | 5.0 | Yes | 1.4 | Yes | 36 |
| Wawa | Yes | 1.0 | No | 0 | No | 0 |
| Horne Payne | Yes | 1.0 | No | 0 | No | 0 |
| **Cochrane District** | | | | | | |
| **Municipality** | | | | | | |
| Cochrane | Yes | 1.0 | No | 0 | No | 0 |
| Hearst | Yes | 2.0 | No | 0 | Yes | 2 |
| Iroquiois Falls | Yes | 1.0 | No | 0 | No | 0 |
| Kapuskasing | Yes | 2.0 | No | 0 | No | 0 |
| Matheson | Yes | 1.0 | No | 0 | No | 0 |
| Moose Factory | No | 0.0 | No | 0 | No | 0 |
| Porcupine | Yes | 2.0 | Yes | 1.4 | No | 0 |
| Smooth Rock Falls | No | 0.0 | No | 0.0 | No | 0 |
| South Porcupine | No | 0.0 | Yes | 0.0 | No | 0 |
| Timmins | Yes | 5.0 | Yes | 2.0 | Yes | 20 |

### Table 5 (Cont'd.)

### Northeast Region

| Nipissing District | Physio-Therapy Dept. | Staff F.T.E.* | Occupational-Therapy Dept | Staff F.T.E.* | Psych. Services Dept. | Available Beds ** |
|---|---|---|---|---|---|---|
| **Municipality** | | | | | | |
| Mattawa | No | 0.0 | No | 0.0 | No | 0 |
| Sturgeon Falls | Yes | 2.0 | No | 0.0 | No | 0 |
| North Bay | Yes | 14.0 | Yes | 7.5 | Yes | 400 |
| **Parry Sound District** | | | | | | |
| **Municipality** | | | | | | |
| Parry Sound | Yes | 2.2 | Yes | 2.7 | No | 0 |
| **Sudbury/Manitoulin District** | | | | | | |
| **Municipality** | | | | | | |
| Espanola | Yes | 4.0 | No | 0.0 | No | 0 |
| Chapleau Little | No | 0.0 | No | 0.0 | No | 0 |
| Current | Yes | 4.0 | No | 0.0 | No | 0 |
| Sudbury | Yes | 23.0 | Yes | 20.6 | Yes | 101 |
| **Timiskaming District** | | | | | | |
| **Municipality** | | | | | | |
| Englehart | Yes | 1.0 | No | 0.0 | No | 0 |
| Kirkland Lake | Yes | 2.0 | No | 0.0 | No | 0 |
| New Liskeard | Yes | 4.0 | No | 0.0 | No | 0 |

*F.T.E. *Full-time Equivalent is the funding equivalent allocated. It is sometimes exceeding but more often unmatched in reality.*

** *"Psychiatric Services hospital beds available" the total beds devoted to psychiatric services within general hospitals as well as beds in psychiatric institutions.*

### Table 6
## Professional Health Care Personnel (North Ontario)
## Personnel by Specialty by District
## Northwest Region Districts

| Specialty | Kenora/ Rainy River | Thunder Bay | Regional Specialty Total |
|---|---|---|---|
| General Practitioners | 60 | 95 | 155 |
| General Surgeons | 2 | 7 | 9 |
| Neurologists | 0 | 2 | 2 |
| Orthosurgeons | 0 | 7 | 7 |
| Psychiatrists | 1 | 3 | 4 |
| Opthalmologists | 0 | 5 | 5 |
| Audiologists | 1 | 2 | 3 |
| Chiropractors | 4 | 20 | 24 |
| Psychologists | 3 | 11 | 14 |
| Social Workers | 2 | 79 | 81 |
| Occupational Therapists | 1 | 31 | 32 |
| Physiotherapists | 17 | 34 | 51 |

*Population Base (1986 Census, Interim Counts): 230,800*

### Table 7

## Professional Health Care Personnel (North Ontario)
## Personnel by Speciality by District
## Northeast Region Districts

| Specialty | Algoma | Cochrane | Sudbury Manitoulin | Nipissing | Parry Sound | Timiska-ming | Regional Specialty Total |
|---|---|---|---|---|---|---|---|
| General | 86 | 82 | 104 | 52 | 28 | 39 | 391 |
| General Surgeons | 11 | 11 | 19 | 5 | 2 | 3 | 51 |
| Neurologists | 0 | 0 | 3 | 0 | 0 | 0 | 3 |
| Orthosurgeons | 3 | 0 | 4 | 2 | 1 | 1 | 11 |
| Psychiatrists | 2 | 5 | 15 | 8 | 0 | 0 | 30 |
| Opthalmologists | 3 | 5 | 4 | 3 | 0 | 0 | 15 |
| Audiologists | 1 | 3 | 2 | 2 | 0 | 0 | 15 |
| Chiropractos | 12 | 13 | 12 | 12 | 2 | 5 | 56 |
| Psychologists | 6 | 4 | 12 | 3 | 0 | 0 | 25 |
| Social Workers | 40 | 7 | 110 | 14 | 1 | 4 | 176 |
| Occup. Therapists | 6 | 2 | 9 | 8 | 2 | 1 | 28 |
| Physiotherapists | 17 | 12 | 20 | 14 | 5 | 7 | 75 |

*Population Base (1986 Census, Interim Counts): 562,418*

## Appendix E

# Guide to Flowchart — WCB

# Guide to an Organizational Flowchart for the Workers Compensation Board as of December 1986

## (Head Office)*

- **Setting up a Claim by Mail,**

*Description of Actions (Boxes)*

1. The employer reports (Form 7s) arrive in the mailroom.
2. The primary adjudicator sorts the Form 7s into lost–time and no–lost–time claims.
3. The no–lost–time (n–l–t) claims adjudicators code and adjudicate the n–l–t claims. (12 n–l–t adjudicators.)
4. Coded n–l–t claims are sent to Records Management to update records.
5. Health Care Benefits Branch Adjudicators do initial assessment and processing of accounts inputted by treating agencies, for transportation, drugs, etc.
6. Accounting approves cheques and then sends them to the mailroom.
7. If Form 7s cannot be paid immediately, the Form 7's are coded according to the adjudication section to which they will be sent. Form 7's are then sent to Records Management for updating of records.
8. Records Management sends forms to the appropriate adjudication section (e.g. Industrial Diseases and Dependents, Initial).

Once claim has been allowed it follows this route:

9. If there is no record, the Records Identification Clerk will establish one.
10. Records Identification Clerk (Records Management) will put claim number on a Form 7 where the client already has an established record.
11. File is sent to data entry for Secondary Input.
12. Claims Payment Clerk (Controller) processes temporary and permanent disability awards.
13. Cheques are sent to accounting for verification.

If claim file is not a last file, it is sent to continuing or pensions adjudication.

**Referral to Downsview and flow of Downsview services not included.*

## *Description of Decisions (Diamonds)*

| | |
|---|---|
| **Decision A** | Sort claims into lost time and no–lost time. |
| *Criteria* | no–lost–time claims are for accidents which necessitated health care treatment but no time off work beyond the day of the accident. |
| *Decision Maker* | Primary Adjudicator, Initial Adjudication Section. |

### Basic Requirements (as per job description)

1. Grade 13 or equivalent combination of accredited academic courses and business experience.
2. At least one year's related experience in either claims adjudication or computing benefits.
3. Ability to communicate well, both orally and in writing.
4. Ability to weigh facts and reach logical decisions quickly.
5. Aptitude for detailed clerical work.

| | |
|---|---|
| *Salary* | $25,587 – $28,305 |

### Number of Primary Adjudicators — 5

| | |
|---|---|
| *Note* | This position is more clerical than other adjudication positions. Therefore, these individuals are not usually considered for the same promotions as the others are. |
| **Decision B** | allow claim (set up for payments) or refer claim.<br>(Cannot deny claim.) |
| *Criteria* | See Appendix A. |
| *Decision Maker* | Primary Adjudicator<br>...as in Decision A. |
| **Decision C** | Decide whether or not to allow payment of claim<br>(Can deny claim.) |
| *Criteria* | See Appendix A. |
| *Decision Maker* | Adjudicator from the Industrial Diseases and Dependents Adjudication Section or the Initial Adjudication Claims Section (for denials forwarded to team co–ordinator). |
| *Reports to* | team co–ordinator of section. |

**Basic Requirements (as per job description)**

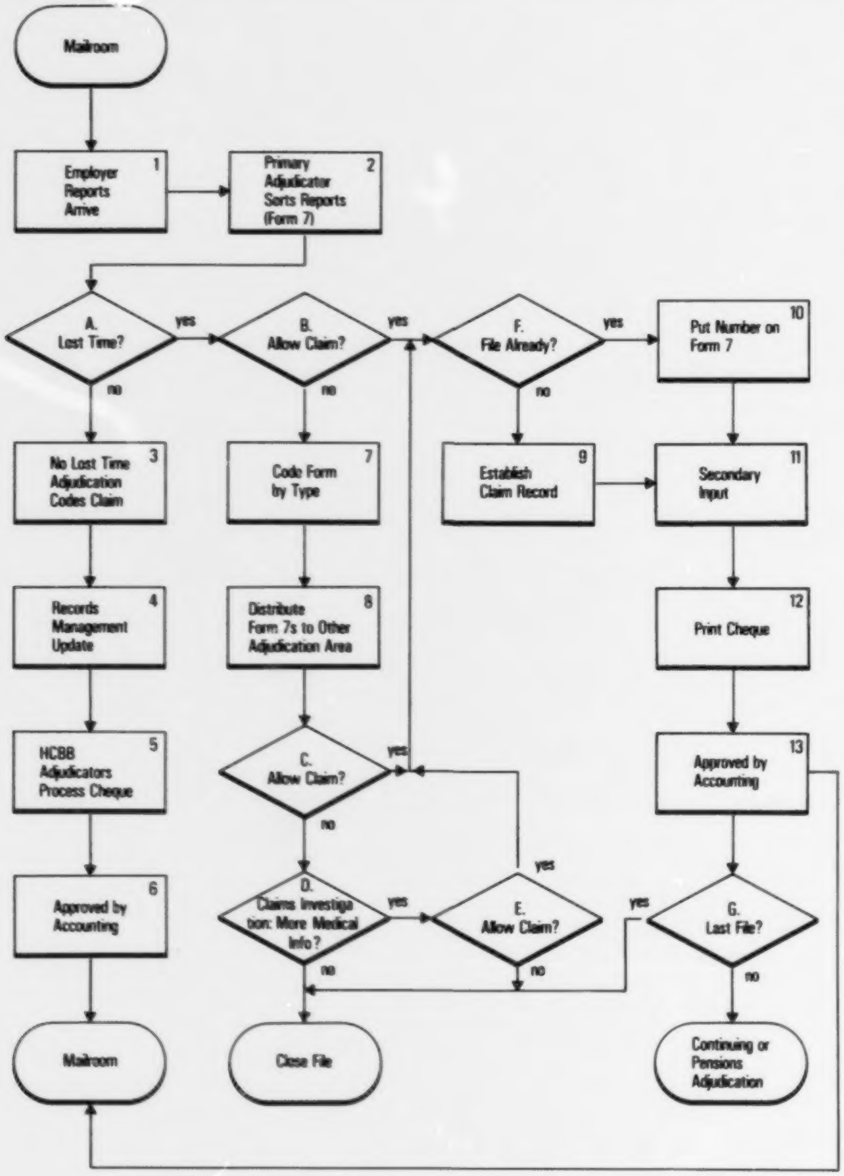
1. Grade 13 education or equivalent combination of accredited academic courses and business experience.

   To become a Senior Adjudicator, must have at least 2 years of adjudication experience.

| | |
|---|---|
| *Training* | 12 weeks of initial training, including 5 weeks of lectures in a classroom setting and 7 weeks of supervised on the job experience.<br>At the end of 12 – 18 months, a further 7 weeks of training comprised of 2 weeks of lectures and 5 weeks of practical training. |
| *Salary* | Junior — $25,591 – $30,663<br>Senior — $30,191 – $36,206 |
| *Number* | 60 Initial Adjudicators, 10 Senior Adjudicators<br>8 Industrial Diseases and Dependent Adjudicators (Head Office) (all senior). |
| *Caseload* | Initial: 100 – 130 / per adjudicator<br>IDDS: 230 – 300 / per adjudicator |
| **Decision D** | Decide whether or not investigation services or medical advice is required. |
| *Decision Maker* | Adjudicator<br>...as in Decision C. |
| **Decision E** | Decide whether or not to allow claim in light of medical and/or investigative advice. |
| *Decision Maker* | Adjudicator<br>...as in Decision C. |
| **Decision F** | Determine whether or not a file already exists. |
| *Decision Maker* | Primary Adjudicator<br>...as in Decision A. |

| | |
|---|---|
| **Decision G** | Last adjudicator to deal with file decides whether it is a closed file or if it should go to continuing or pensions adjudication....as in Decision C. |
| *Salary* | As per Junior and Senior above<br>Number of Pension Adjudicators — 22 (Senior)<br>Number Continuing Adjudicators — Senior: 120<br>Junior: 60 (Head Office) |
| *Caseload* | Pensions — not applicable<br>Continuing Junior — 190 – 200 / per adjudicator<br>Senior — 205 – 215 / per adjudicator |

## Setting Up a Claim by Mail


Mailroom
Employer Reports Arrive 1
Primary Adjudicator Sorts Reports (Form 7) 2
A. Lost Time?
yes
no
B. Allow Claim?
yes
no
F. File Already?
yes
no
Put Number on Form 7 10
No Lost Time Adjudication Codes Claim 3
Code Form by Type 7
Establish Claim Record 9
Secondary Input 11
Records Management Update 4
Distribute Form 7s to Other Adjudication Area 8
Print Cheque 12
HCBB Adjudicators Process Cheque 5
C. Allow Claim?
yes
no
Approved by Accounting 13
yes
Approved by Accounting 6
D. Claims Investigation: More Medical Info?
yes
no
E. Allow Claim?
no
yes
G. Last File?
no
Mailroom
Close File
Continuing or Pensions Adjudication

### • Setting up a Claim by Telephone

#### *Descriptions of Actions (Boxes)*

14. Caller contacts general enquiry who contacts Telephone Enquiry Clerk in the Claims Services Division (located on 9th, 14th, 16th and 17th floors).

15. Telephone Enquiry Clerk refers file to another Claims Division employee.

16. Form 0262 or W262 is completed (equivalent to a Form 7).

17. Form is sent to Records Management for an update of records.

#### *Description of Decisions (Diamonds)*

| | |
|---|---|
| **Decision H** | Decide whether or not to record claims information, or to refer. (Any claims division employee can set up a claim.) |
| *Criteria* | Is this difficult? Am I too busy? |
| *Decision Maker* | Telephone Enquiry Clerk, Claims Administrative Services Branch. |
| *Reports To* | Supervisor, Claims Telephone Enquiry Services. |

**Basic Requirements (as per job description)**

1. Grade 12 or equivalent combination of education and experience.

2. One to three years related experience.

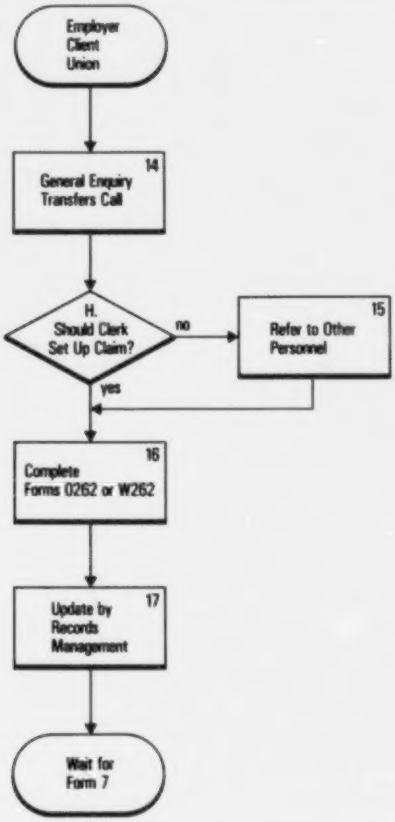
3. Effective communication skills.

4. As required, able to work variable hours to provide essential services.

5. Working knowledge of Claims Services Division and WCB's operation.

6. Additional language facility would be an asset.

## Setting Up a Claim by Telephone


Employer
Client
Union
14
General Enquiry
Transfers Call
H.
Should Clerk
Set Up Claim?
no
yes
15
Refer to Other
Personnel
16
Complete
Forms 0262 or W262
17
Update by
Records
Management
Wait for
Form 7

## • Setting up a Claim in Person

### *Description of Actions (Boxes)*

18. Receptionist Counsellor (6th Floor) takes basic information and asks client to wait until claims counsellor is available.

19. Claims Counsellor sets up claim using form 0262 or W262.

20. Senior Claims Counsellor sets up claim if it requires more expertise (using form 0262 or W262).

21. Form is sent to Records Management for update of record.

### *Descriptions of Decisions (Diamonds)*

| | |
|---|---|
| **Decision A** | Should I set up claim or is this a case which requires more expertise? Should I assign client to a Senior Claims Counsellor? (Claims Counsellors don't adjudicate.) |
| *Decision Maker* | Claims Counsellor, Claims Administrative Services |
| *Reports to* | Supervisor, Claims Enquiry Section. |

**Basic Requirements (as per job description)**

1. Grade 13 or equivalent combination of education and experience.

2. Three years related experience in claims adjudication or counselling.

3. Effective communication skills such as interviewing, report writing and counselling.

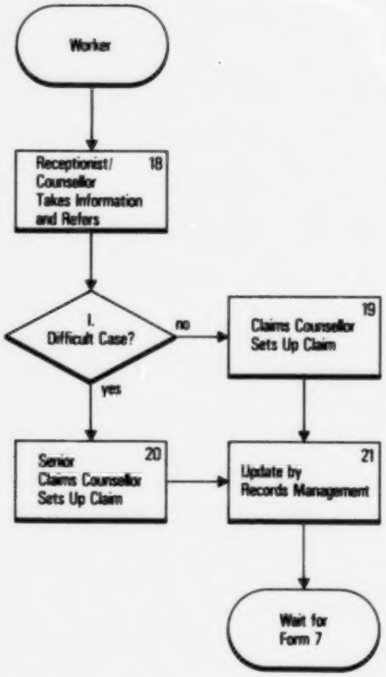
4. Established ability to work with people.

5. Must be able and willing to travel as required.

6. Additional language facility would be an asset.

| | |
|---|---|
| *Salary* | $24,666 – $31,970 |
| *Number* | Claims Counsellors — 15 |
| *Caseload* | Average of 14 claims/per day/per counsellor |

## Setting Up a Claim in Person


Worker
Receptionist/ Counsellor Takes Information and Refers
18
I. Difficult Case?
no
yes
19
Claims Counsellor Sets Up Claim
20
Senior Claims Counsellor Sets Up Claim
21
Update by Records Management
Wait for Form 7

## • Internal Referrals to Vocational Rehabilitation Division

### *Descriptions of Actions (Boxes)*

22. Request for vocational rehabilitation is referred to the Rehabilitation Service Controllers Section, Rehabilitation Resources.

23. If the Rehabilitation Service Controller does not believe that client is eligible he/she refers the file to the co–ordinator of the Rehabilitation Service Controllers for eligibility determination.

24. If the client is deemed eligible, the rehabilitation Service Controller contacts the client to ask if he/she is interested and ready to see a counsellor. If so, the Rehabilitation Service Controller tells the client that a counsellor will be in contact.

25. If the client is not interested, a memo is sent to the claims adjudicator or other board employee who made the referral.

26. If the client is interested and ready for service, the Rehabilitation Service Controller creates a vocational rehabilitation file and assigns a disposition to the case. Disposition is a code describing information about the client (i.e. capable for light work, language spoken, benefit status, etc.).

27. If this not a difficult case, the disposition will be sent to the Systems Planning and Management Information Section (SPMI). The SPMI clerk will then assign the case to a field counsellor (via terminal) based on geographic location, schedule type and language capability.

28. If the Rehabilitation Service Controller and supervisor decide that the client will be difficult to place, they will refer directly to a Rehabilitation Specialist.

    *Note: if injury is deemed serious by the adjudicator, referral will be made immediately (within 1 – 3 days of claim receipt) to the Rehabilitation Specialist Section. Process listed above will not apply.*

29. Once the referral is made, the Field Counsellor or the Rehabilitation Specialist will set up an initial contact date by telephone or correspondence.

30. Supportive/social counselling may be provided if the counsellor deems it necessary.

    May be provided by counsellor or Downsview psychologists, psychiatrists and social workers.

31. Primary vocational rehabilitation plan is set up (concentrates on return to accident employer).

32. Contact between 4 – 6 weeks after *full* employment (contact by telephone, correspondence or in person) prior to closure of file. Exceptions require supervisory approval.

33. Develop alternative vocational rehabilitation plan.

    Normally considered only after employment with accident or other employer is ruled out.

    - may involve agency assessments
    - may involve academic upgrading, skills training, Training on the Job Programs or work assessments
    - may involve contact with placement specialist.

## Description of Decisions (Diamonds)

| | |
|---|---|
| **Decision J** | Determine eligibility for referral to the Vocational Rehabilitation Division. |
| *Criteria* | (See Appendix C for eligibility criteria.) |
| *Decision Maker* | Adjudicator ... as in Decision C. |
| | Vocational Rehabilitation is usually involved at continuing and pension adjudication stage. |
| | Primary adjudicators do not make referrals to Vocational Rehabilitation. |
| | If the Primary Adjudicator receives a Form 7 regarding a "serious" injury, he/she will immediately (1 – 3 days) deliver it to Record Management who will then deliver it to Initial Adjudication. |
| **Decision K** | Determine whether or not client is a reopened file. |
| *Decision Maker* | Rehabilitation Service Controller, Rehabilitation Resources Branch. |
| *Reports to:* | Co–ordinator, Rehabilitation Service Controllers. |

**Basic Requirements (as per job description)**

1. Grade 12 or equivalent combination of education and experience.
2. Minimum of three years related experience.
3. Effective communication skills.
4. Ability to exercise tact, diplomacy and good judgement.

| | |
|---|---|
| *Salary* | $23,395 – $28,613 |
| *Number of* | Rehabilitation service controllers — 5 |
| *Caseload* | 12 – 15 files/per controller at any given time (2–day turnaround standard). |
| **Decision L** | Determine whether or not this is a complex case. If so, refer to Preliminary Rehabilitation Counsellor for entitlement interview. |
| *Decision Maker* | Rehabilitation Service Controller ... As in Decision K |

| | |
|---|---|
| **Decision M** | Determine whether or not client is eligible for vocational rehabilitation services. |
| *Criteria* | (See Appendix C for eligibility criteria.) |
| *Decision Maker* | Rehabilitation Service Controller ... As in Decision K |
| **Decision N** | further determination about eligibility for Vocational Rehabilitation |
| *Criteria* | (See Appendix D for eligibility criteria) |
| 1986 | 1 formal denial and 20% of referrals were deferred |
| *Decision Maker* | Co-ordinator of Rehabilitation Service controllers. |
| **Decision O** | Determine whether client is interested in vocational rehabilitation |
| *Criteria* | Have they already found a job?<br>Do they feel ready to begin looking for work?<br>Does MD feel they are ready to begin looking for work? |
| *Decision Makers* | Rehabilitation Service Controller and client ... As in decision K |
| **Decision P** | Will this be a difficult placement?<br>severity of injury<br>past work history<br>psychiatric difficulties |
| *Decision Maker* | Rehabilitation Service Controller (with guidance of co-ordinator) ... As in decision K |
| **Decision Q** | Should pre-vocational services be provided: social, supportive counselling, credit counselling, psychological testing, agency assessment (at Downsview, Head Office or outside agency/professional). |
| *Decision Maker* | Field Rehabilitation Counsellor (FRC) or Rehabilitation Specialist. |
| *Reports To* | FRC reports to Administrator of Vocational Counselling Rehabilitation Specialist, who reports to Administrator, Rehabilitation Specialists. |

**Basic Requirements (as per job description)**

*FRC — Level 1 (higher level)*

1. University graduation preferred or the equivalent in specialized training or experience.
2. A minimum of three years experience in related work with above-average performance as a Rehabilitation Counsellor, Level 2.
3. Demonstrated superior ability to deal satisfactorily with difficult or complex rehabilitation problems.
4. Membership in the Canadian Association of Rehabilitation Personnel and willingness to proceed to accredited status.
5. Willingness to travel. Will be required to provide own transportation.

*FRC — Level 2*

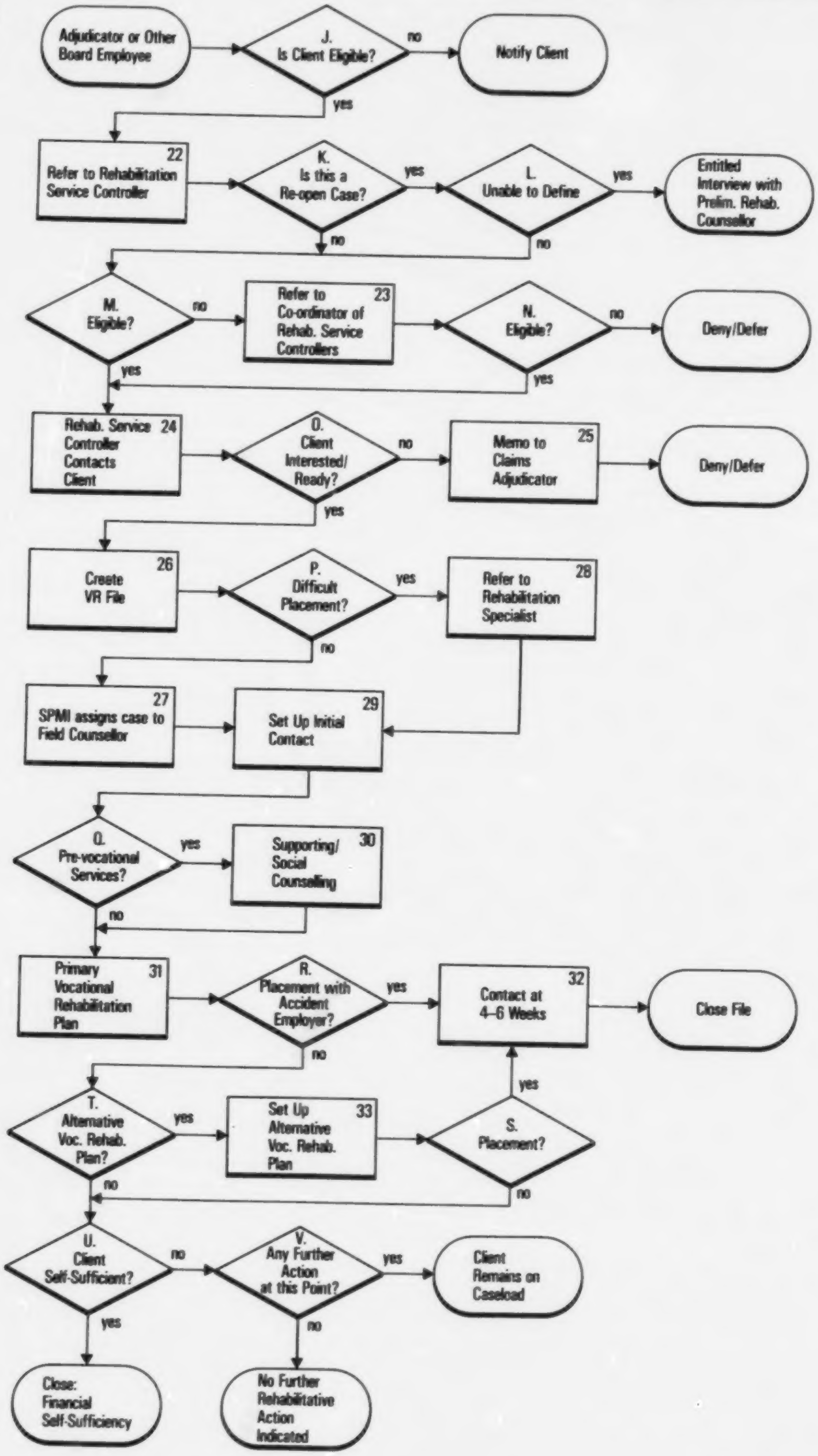
1. University graduation preferred or the equivalent in specialized training or experience.
2. Readiness to undertake directed reading and special training in rehabilitation Be acceptable for membership in the Canadian Association of Rehabilitation Personnel and willing to proceed to accredited status. Be prepared to undertake Rehabilitation Counselling Certification Course.
3. Skill in interviewing, ability to communicate both orally and in writing. Ability to work well with people. And genuine interest in returning injured workers to suitable employment.
4. Over one and preferably three years related experience.
5. Willingness to travel. Will be required to provide own transportation.

*Rehabilitation Specialist*

1. University graduation preferred or Grade 13 plus specialized training such as a Rehabilitation Counselling Certificate or equivalent.
2. A minimum of three years experience in related work with above average performance as a Rehabilitation Counsellor 1.
3. Demonstrated superior ability to deal satisfactorily with difficult or complex rehabilitation problems.
4. Good working knowledge of the WCB's operations.
5. Accreditation status with the Canadian Association of Rehabilitation Personnel.
6. Ability to communicate both orally and in writing at all levels.
7. Willingness to relocate.
8. Required to provide own transportation.

| | |
|---|---|
| Salary: | Rehabilitation Counsellor (2)<br>$28,964 – $37,729/annum<br>Rehabilitation Counsellor (1)<br>$30,955 – $40,313/annum<br>Rehabilitation Specialist<br>$35,529 – $45,775/annum |
| *Number of Toronto Field Counsellors:* | 87 (including temps) (January 1987) |
| *Number of Rehabilitation Specialists:* | 8 (January 1987) |
| *Caseload* | Field counsellors average 75.1 cases per counsellor (December 1986), allocated primarily by geographic region (Ontario). Rehabilitation Specialists average 45.4 per specialist (Dec/86) |
| *Training* | 9–week course at outset (entry level point). |
| **Decisions R & S** | Does placement occur?<br>(e.g., accident employer, new employer, self–employed) |
| *Decision Maker* | Field Counsellor (Level 1 or Level 2) or Rehabilitation Specialist |
| **Decision T** | Is an alternative vocational rehabilitation plan necessary?<br>(e.g. job search with another employer; retraining). |
| *Decision Maker* | Field counsellor or rehabilitation specialist |
| **Decision U** | Is client financially self–sufficient? (i.e. has enough financial resources in combination with Canada Pension Plan equivalent?). |
| *Decision Makers* | Field Counsellor or specialist and client |
| **Decision V** | Any further rehabilitation action needed at this point? If not, client will be closed under one of the "No Further Rehabilitation Action Indicated Categories" (see Appendix F for closure categories). If so, client will remain on caseload. |

## Internal Referrals to the Vocational Rehabilitation Division


Adjudicator or Other Board Employee
J. Is Client Eligible?
no
Notify Client
yes
22 Refer to Rehabilitation Service Controller
K. Is this a Re-open Case?
yes
L. Unable to Define
yes
Entitled Interview with Prelim. Rehab. Counsellor
no
no
M. Eligible?
no
23 Refer to Co-ordinator of Rehab. Service Controllers
N. Eligible?
no
Deny/Defer
yes
yes
24 Rehab. Service Controller Contacts Client
O. Client Interested/ Ready?
no
25 Memo to Claims Adjudicator
Deny/Defer
yes
26 Create VR File
P. Difficult Placement?
yes
28 Refer to Rehabilitation Specialist
no
27 SPMI assigns case to Field Counsellor
29 Set Up Initial Contact
Q. Pre-vocational Services?
yes
30 Supporting/ Social Counselling
no
31 Primary Vocational Rehabilitation Plan
R. Placement with Accident Employer?
yes
32 Contact at 4–6 Weeks
Close File
no
yes
T. Alternative Voc. Rehab. Plan?
yes
33 Set Up Alternative Voc. Rehab. Plan
S. Placement?
no
no
U. Client Self-Sufficient?
no
V. Any Further Action at this Point?
yes
Client Remains on Caseload
yes
no
Close: Financial Self-Sufficiency
No Further Rehabilitative Action Indicated

## • External Referrals to Vocational Rehabilitation Division

### *Description of Actions (Boxes)*

34. Client walks into 6th floor of Head Office and requests an appointment with Preliminary Rehabilitation Counsellor (PRC).

35. Waits in waiting area for entitlement interview with PRC.

36. Entitlement interview is conducted may require more than one session. Sessions last approximately one hour.

37. If Preliminary Rehabilitation Counsellor decides client is not "job ready", he/she will refer case to a field counsellor or rehabilitation specialist.

38. If Preliminary Rehabilitation Counsellor decides client is job ready, will refer case to himself/herself and concentrate on placement with accident employer or other direct placement.

39. Once client is fully employed, the Preliminary Rehabilitation Counsellor will contact client.

40. Once the referral is made, the field counsellor or the rehabilitation specialist will set up an initial contact date by telephone or correspondence.

41. Supportive/social counselling may be provided if the counsellor deems it necessary.

42. Primary vocational rehabilitation plan is set up (concentrates on return to accident employer).

43. Contact between 4 6 weeks after *full* employment (contact by telephone, correspondence or in person) prior to closure of file. Exceptions require supervisory approval.

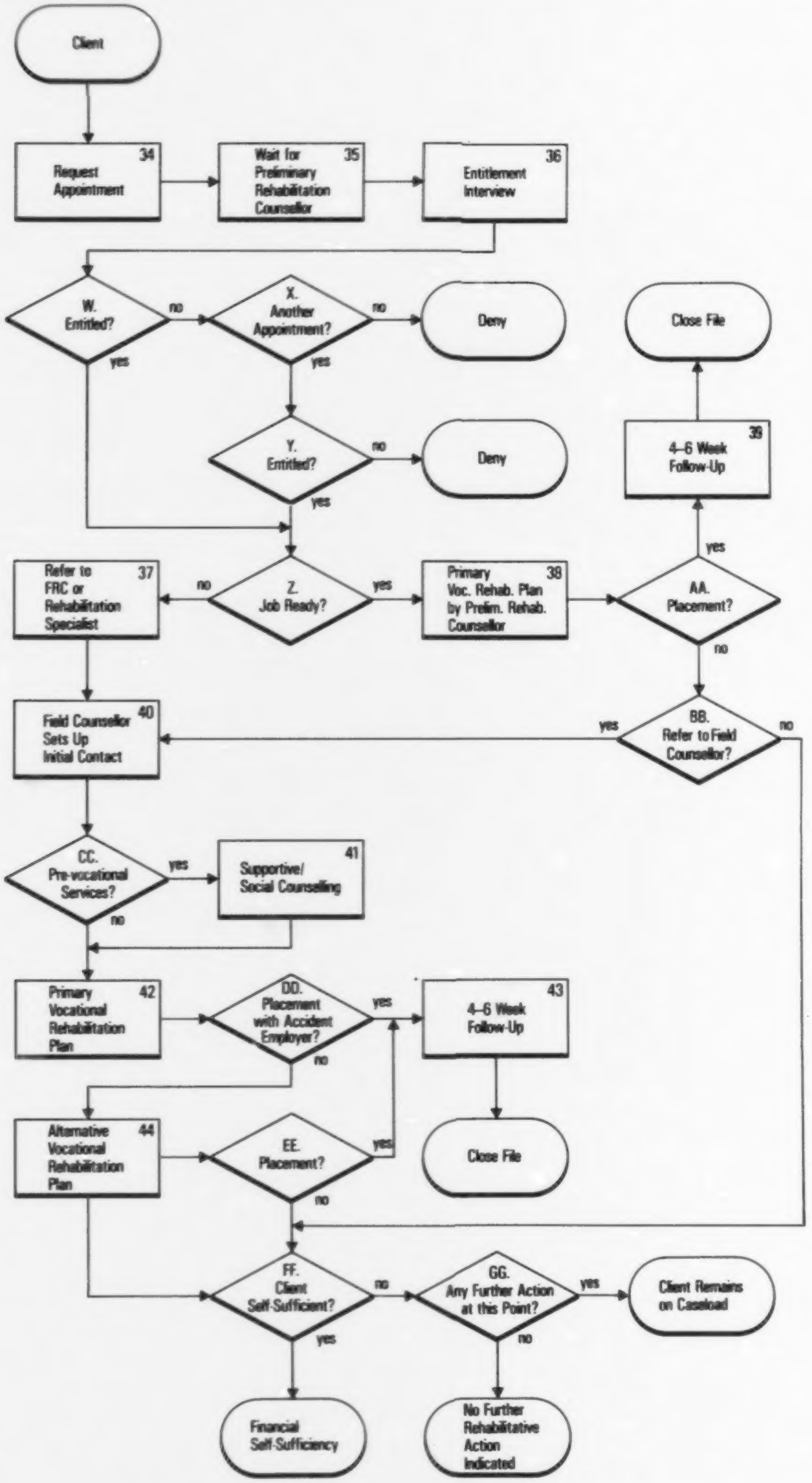
44. Develop alternative vocational rehabilitation plan.

### *Description of (Decisions Diamonds)*

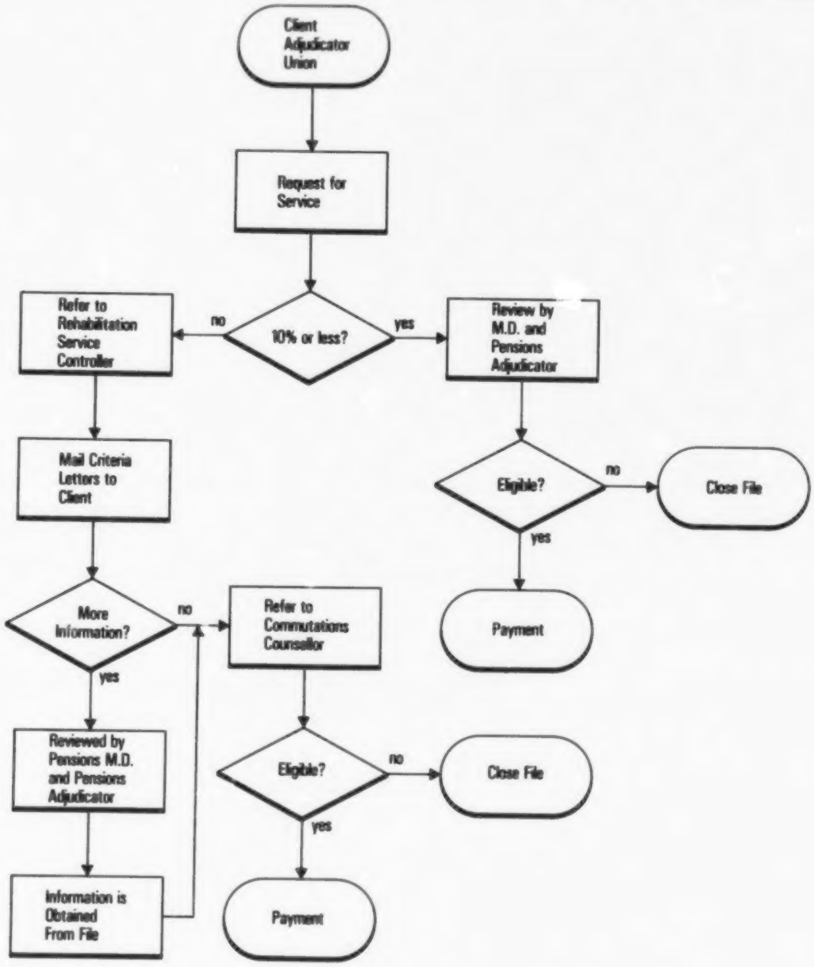
| | |
|---|---|
| **Decision W** | Decide whether or not client is eligible for Vocational Rehabilitation on basis of entitlement interview based on board policy. |
| *Criteria* | (See Appendix E for information obtained in entitlement interview and Appendix D for board policy). |
| *Decision Maker* | Preliminary Rehabilitation Counsellor. |
| *Reports to* | Administrator of Preliminary Counsellors. |
| *Basic Requirements* | (As per job description) |

| | |
|---|---|
| *Salary:* | Rehabilitation Counsellor 2<br>$26,254 – $34,193/annum<br>Rehabilitation Counsellor 1<br>$28,054 – $36,523/annum |
| *Number* | Preliminary Rehabilitation Counsellors: 6 (December 1986) |
| *Caseload* | 40 – 50/counsellor (Dec, 1986) |
| • | PRC's spend approximately half of their time conducting entitlement interviews and half of their time counselling clients and servicing an out-of-province caseload |
| **Decision X** | Decide whether another appointment is necessary |
| *Criteria* | Has all information been gathered |
| *Decision Maker* | Preliminary Rehabilitation Counsellor (PRC) ... As in Decision W |
| **Decision Y** | Same as Decision W |
| **Decision Z** | Decide whether or not client is "job ready."<br>If so, Preliminary Rehabilitation Counsellor takes case himself/herself |
| *Criteria* | Based on information outlined in Appendix E |
| *Decision Maker* | Preliminary Rehabilitation Counsellor |
| **Decision AA** | Can client be placed relatively quickly? |
| *Decision Maker* | Preliminary Rehabilitation Counsellor |
| **Decision BB** | Should client be referred to a field counsellor? |
| *Decision Maker* | Preliminary Rehabilitation Counsellor |
| **Decision CC** | As in Decision Q |
| **Decision DD** | As in Decision R |
| **Decision EE** | As in Decision S |
| **Decision FF** | As in Decision U |
| **Decision GG** | As in Decision V |

## External Referrals to the Vocational Rehabilitation Division

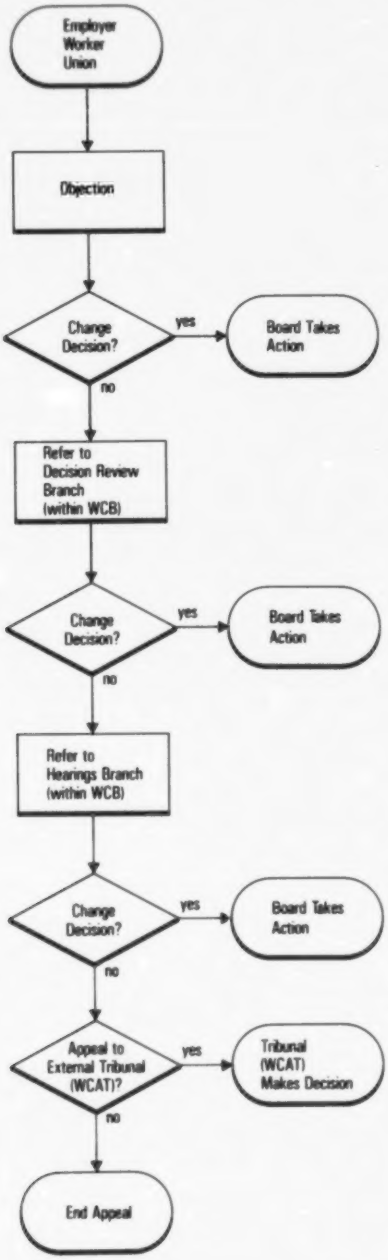

Client
34 Request Appointment
35 Wait for Preliminary Rehabilitation Counsellor
36 Entitlement Interview
W. Entitled?
no
yes
X. Another Appointment?
no
yes
Deny
Y. Entitled?
no
yes
Deny
Close File
39 4–6 Week Follow-Up
yes
37 Refer to FRC or Rehabilitation Specialist
no
Z. Job Ready?
yes
38 Primary Voc. Rehab. Plan by Prelim. Rehab. Counsellor
AA. Placement?
no
40 Field Counsellor Sets Up Initial Contact
yes
BB. Refer to Field Counsellor?
no
CC. Pre-vocational Services?
yes
no
41 Supportive/ Social Counselling
42 Primary Vocational Rehabilitation Plan
DD. Placement with Accident Employer?
yes
no
43 4–6 Week Follow-Up
Close File
44 Alternative Vocational Rehabilitation Plan
EE. Placement?
yes
no
FF. Client Self-Sufficient?
no
yes
GG. Any Further Action at this Point?
yes
no
Client Remains on Caseload
Financial Self-Sufficiency
No Further Rehabilitative Action Indicated

## Commutation of Pension


Client
Adjudicator
Union
Request for Service
10% or less?
no
yes
Refer to Rehabilitation Service Controller
Review by M.D. and Pensions Adjudicator
Mail Criteria Letters to Client
Eligible?
no
Close File
yes
Payment
More Information?
no
Refer to Commutations Counsellor
yes
Reviewed by Pensions M.D. and Pensions Adjudicator
Eligible?
no
Close File
yes
Information is Obtained From File
Payment

## Review and Appeal Process

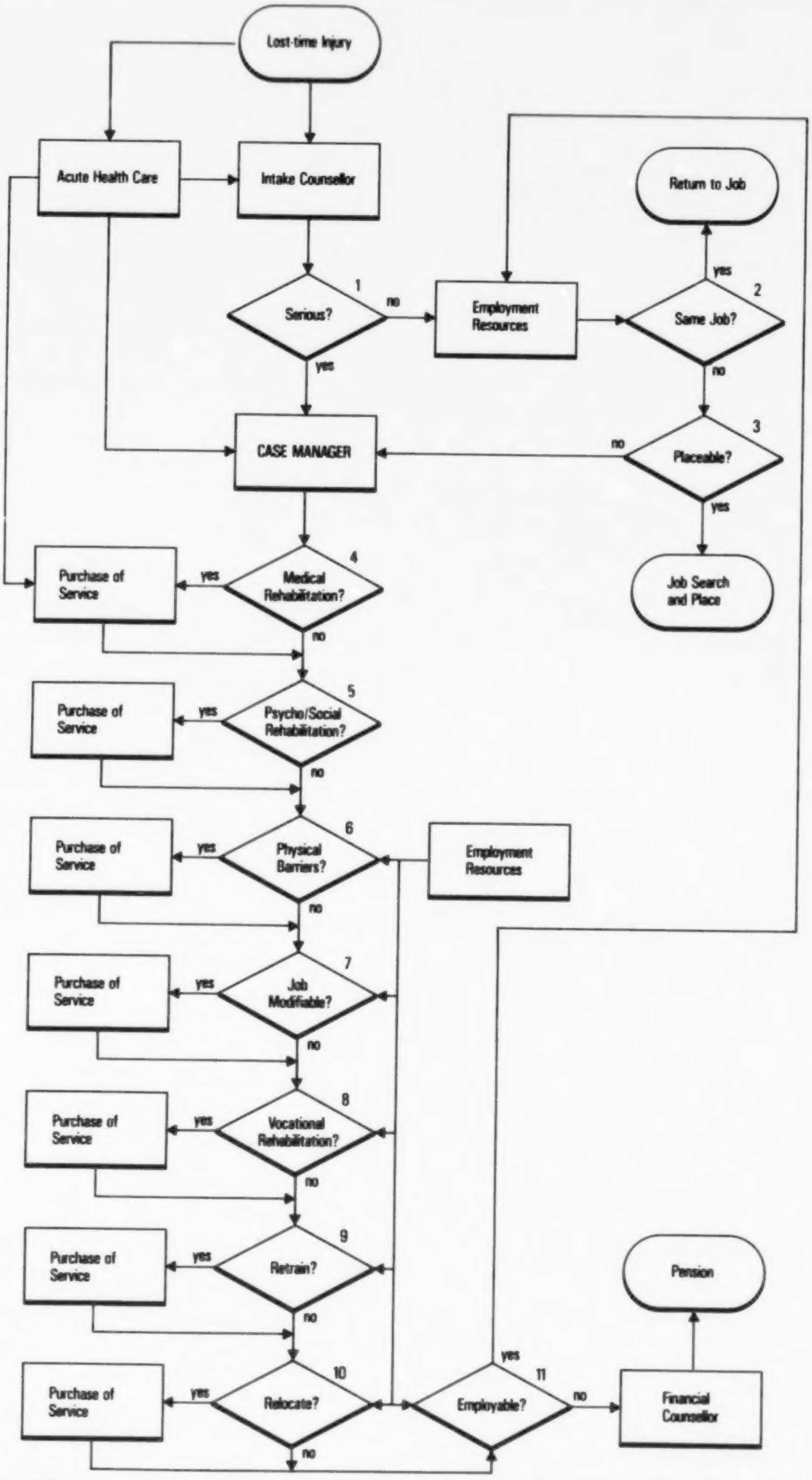
**Note:**
**Client may apply for a reconsideration of a WCAT decision and WCB Board of Directors may direct WCAT to reconsider a decision.**
**Section (86).**


Employer
Worker
Union
Objection
Change Decision?
yes
Board Takes Action
no
Refer to Decision Review Branch (within WCB)
Change Decision?
yes
Board Takes Action
no
Refer to Hearings Branch (within WCB)
Change Decision?
yes
Board Takes Action
no
Appeal to External Tribunal (WCAT)?
yes
Tribunal (WCAT) Makes Decision
no
End Appeal

## Appendix F

# Proposed Rehabilitation System

## Proposed Rehabilitation System


Lost-time Injury
Acute Health Care
Intake Counsellor
Return to Job
1
Serious?
no
yes
Employment Resources
2
Same Job?
yes
no
CASE MANAGER
3
Placeable?
no
yes
Job Search and Place
4
Medical Rehabilitation?
yes
no
Purchase of Service
5
Psycho/Social Rehabilitation?
yes
no
Purchase of Service
6
Physical Barriers?
yes
no
Purchase of Service
Employment Resources
7
Job Modifiable?
yes
no
Purchase of Service
8
Vocational Rehabilitation?
yes
no
Purchase of Service
9
Retrain?
yes
no
Purchase of Service
Pension
10
Relocate?
yes
no
Purchase of Service
11
Employable?
yes
no
Financial Counsellor

## Guide to Flowchart

The following pages describe the flow of client services from the time of injury of a worker on the job or the recognition of the existence of an industrial disease.

Details of the service-delivery model that are of secondary importance are omitted since these can be developed as required. The main objective of the flowchart is to describe the proposed rehabilitation system in such a way as to highlight its uniqueness, philosophy and the changes from the existing system.

The main features of this proposed system include:

- Acute Health Care reports to the intake counsellor who determines the seriousness of the injury.
- The case manager manages the client file from the time a decision of rehabilitation needs is determined, during the full period in which rehabilitation services are offered and until final follow-up, one year following termination of the service.
- All decisions to purchase rehabilitation services are made by the case manager together with the injured worker following consultation with the appropriate people, internal and external to the WR & CB (e.g., medical personnel, employers, etc.).
- Goals of rehabilitation include
  - vocational placement
  - economic independence
  - quality of life on par with comparable non-injured workers
  - physical independence
  - psychosocial adjustment and stability

## *LOST–TIME INJURY*

1. All injuries must be reported by Acute Health Care, the employer and the injured worker to a claims adjudicator.
2. The primary adjudicator receives all claims and sorts them into lost–time and no–lost–time claims. This decision is mainly clerical and no special training is required.
3. If Acute Health Care deems an injury to be serious (see glossary for definition) the injury must be reported immediately to the primary adjudicators who, without waiting for all the necessary papers to arrive, will refer the file to the intake counsellor to initiate rehabilitation services.

## *ACUTE HEALTH CARE*

This may be a hospital, clinic, or private medical doctor. In any of these cases, the responsible individual is the physician in charge.

## *INTAKE COUNSELLOR*

### Essential Characteristics and Training

- training in rehabilitation counselling
- training in assessing impact of injuries
- empathy with injured workers
- good interpersonal skills

### Functions

- to decide on the seriousness of an injury
- to reduce the client's anxiety by helping him/her face and realistically assess problems
- to act as a member of the rehabilitation team

### Responsibilities

- to be knowledgeable about the impact of injuries
- to maintain close contact with Acute Health Care
- to be knowledgeable about employment standards and requirements

## Decision # 1

### *"IMPACT SERIOUS?"*

**Description of Decision**

**Input for Decision**

- from injured worker
- from employer
- from Acute Health Care

**Criteria for Decision**

- the injury results in a lost-time claim
- assessed ability, or inability, to return to previous employment based on both visible and invisible injuries
- the client has not returned to work within 30 days

**Outcomes of Decision**

**Yes**

- referral to case manager

**No**

- referral to Employment Resources (see page 277)

## Decision #2

### *"SAME JOB?"*

**Description of Decision**

Employment Resources must determine if the injured worker can return to original job.

**Input for Decision**

- from injured worker
- from Acute Health Care
- from employer

**Criteria for Decision**

- assessed ability to perform original job
- availability of original job

**Outcomes of Decision**

**Yes**

- place in previous job

**No**

- referral to Decision #3

## Decision #3

### *"PLACEABLE?"*

**Description of Decision**

Employment Resources must determine if the injured worker can be placed on a job different from the previous one but without the need for rehabilitation services. At this point it has been ascertained that the injury is not serious but original employment is impossible.

**Input for Decision**

- from injured worker
- from employer
- from Acute Health Care

**Criteria**

- original job unavailable
- willingness of injured worker to try placement at another job

**Outcomes of Decision**

**Yes**

- job search
- placement

**No**

- recognition of need for rehabilitation services
- referral to case manager for rehabilitation services

## *EMPLOYMENT RESOURCES*

### Essential Characteristics and Training

- knowledgeable about the world of work
- good communications skills
- empathy with injured workers

### Functions

- to advise the case manager in all things relating to vocational and employment rehabilitation
- to obtain job listings by good communications with employers
- to match jobs to injured workers
- to find placement positions for injured workers

### Responsibilities

- to keep abreast of needs of industry by maintaining frequent contacts, visits and communications
- to keep listings of possible jobs
- to help employers understand the positive nature of rehiring of injured workers

## CASE MANAGER

### Essential Characteristics and Training

- trained in counselling skills
- trained in management skills
- knowledge of the workplace
- able to make responsible decisions regarding rehabilitation and employability using advice from other professionals
- able to reduce the client's anxiety and help him/her achieve emotional and intellectual acceptance of the limitations imposed by the disability
- open to continuous process of learning
- good interpersonal skills
- willingness to help the client decide on and work towards the best rehabilitation services available
- eagerness to help injured workers achieve independence

### Functions

- to effectively organize and co–ordinate a system whereby individual clients are provided services that will lead to economic independence and an acceptable level of quality of life and dignity
- to supply crisis counselling services where necessary to one's level of skills
- to determine the need for and to purchase rehabilitation services as required
- to effect a smooth, rapid and effective flow of cases and services, with maximum return from purchased services that will be utilized in restoring clients to the most independent status of which they are capable
- to follow up clients for one year after closing a case
- to seek input from clients regarding the quality of service offered

### Responsibilities

- under supervision, to make all rehabilitation decisions in concert with the injured worker
- to consult with appropriate people before making these decisions
- to keep abreast of new techniques of rehabilitation by reading, studying, attending conferences, etc.
- to continue to be aware of changes in the workplace that affect employability

### NOTE

The following eight sets of decisions that are made by the case manager may be consecutive, concurrent or in any other combination. The decisions must be individualized and tailored to the needs of each client. The rehabilitation philosophy underlying this set of decisions must reflect a holistic approach towards rehabilitation.

## Decision #4

### *"MEDICAL REHABILITATION?"*

#### Description of Decision

At this point the case manager has received a case that has been deemed to be a serious one and that without rehabilitation services placement is impossible. The decisions that the case manager must make are extremely important since they determine the types of rehabilitation that will be offered. Since all injured workers have the right to rehabilitation whether it will lead to employment or not, no decision to offer rehabilitation is required.

Decision #4 pinpoints medical rehabilitation.

#### Input into Decision

- from injured worker
- from Acute Health Care
- from intake counsellor
- from placement counsellor

#### Criteria for Decision

- willingness of injured worker to receive rehabilitation services
- recognition that medical rehabilitation is appropriate

#### Outcomes of Decision

**Yes**

- purchase of medical rehabilitation
- purchase of physical rehabilitation
- monitoring of appropriateness of purchased services

**No**

- referral to other decisions

### *PURCHASE OF SERVICE A*

#### Medical

On the advice of Acute Health Care physicians, the case manager in partnership with the injured worker, will decide on appropriate medical and paramedical rehabilitation services. The services may include physical and functional assessment and related therapeutic interventions, including appropriate testing and evaluation, performed by services recommended by the attending physician.

Where involvement of a WCRB physician is deemed appropriate by the case manager, the physician shall be requested to reassess the injured worker and report the findings to the case manager.

## Decision #5

### *"PSYCHOSOCIAL REHABILITATION?"*

**Description of Decision**

Injuries are recognized to have psychological and sociological impacts. The case manager must be sensitive to the degree and nature of the invisible injury and must choose appropriate intervention strategies.

**Input for Decision**

- from injured worker and family
- from Acute Health Care

**Criteria for Decision**

- recognition that psychosocial services are appropriate
- inability to deliver these services him/herself
- willingness of injured worker to receive services

**Outcomes of Decision**

**Yes**

- purchase of psychological and psychiatric assessment
- purchase of appropriate intervention services; psychological, psychiatric, social work, rehabilitation counsellor, family counsellor, financial counsellor, etc.
- monitoring of appropriateness of purchased services

**No**

- referral to other decisions

### *PURCHASE OF SERVICE B*

**Psychosocial**

At the discretion of the case manager, and in partnership with the injured worker, services may be purchased from psychiatrists, psychologists, social workers and other social–service professionals in order to assess and reduce the impact of invisible injuries on the injured worker.

It is recognized that while the goals of intervention of psychosocial aspects of rehabilitation are primarily to return the injured worker to vocational independence they also include goals of independence and stability in all other aspects of life.

## Decision #6

### *"PHYSICAL BARRIERS?"*

**Description of Decision**

In order for an injured worker to be able to interact freely with the environment, physical barriers may have to be removed. These may exist in the injured worker, such as a need for prostheses, or they may exist in the environment and require such intervention as modifications to a home, a car, etc. Whether eventual outcome will be placement or acceptable quality of life, such barriers must be removed.

**Input for Decision**

- from knowledgeable people
- from Employment Resources

**Criteria for Decision**

- recognition that physical barriers exist
- willingness of injured worker to receive services

**Outcomes of Decision**

**Yes**

- purchase of appropriate services: prostheses, modifications to transportation, home, etc.
- monitoring of appropriateness of purchased service

**No**

- refer to other decisions

### *PURCHASE OF SERVICE C*

**Barriers**

The case manager, in partnership with the injured worker, will purchase services necessary to reduce the physical and social impact of the environment on the disability of the injured worker, in order to remove any barriers that decrease the injured worker's independence in all phases of life.

## Decision #7

### *"JOB MODIFIABLE?"*

**Description of Decision**

Since return to the original job was impossible, a decision must be made if the original workplace can be modified so that the injured worker can return to the previous employer.

**Input for Decision**

- from Employment Resources
- from ergonomics adviser
- from employer
- from Acute Health Care
- from psychosocial professionals

**Criteria for Decision**

- inability to place in original job
- willingness of injured worker to return to modified job
- willingness of employer to modify job

**Outcomes of Decision**

**Yes**

- modification of workplace
- placement

**No**

- refer to other decisions

### *PURCHASE OF SERVICE D*

**Job Modification**

The case manager, together with the injured worker and the employer, will act to modify the conditions of the job or worksite to make it more accessible and suitable for the injured worker.

## Decision #8

### *"VOCATIONAL REHABILITATION?"*

**Description of Decision**

A fundamental goal of rehabilitation is the restoration of the injured worker to economic independence, preferably by placement on a job. This may require vocational assessment and work–adjustment training. Decisions in this regard must be made if a decision of employability is to be the outcome.

**Input for Decision**

- from Employment Resources
- from injured worker
- from industry
- from knowledgeable people in the field of pre–vocational and vocational rehabilitation

**Criteria for Decision**

- willingness of injured worker to receive services

**Outcomes of Decision**

**Yes**

- purchase of vocational assessment
- purchase of work–adjustment services
- monitoring of appropriateness of purchased services

**No**

- referral to Decision #8

### *PURCHASE OF SERVICE E*

**Vocational Rehabilitation**

The case manager, in partnership with the injured worker, will arrange for vocational assessment, work assessment and work–adjustment services in organizations and institutions that can demonstrate a high level of service, taking into account the needs of people who have sustained physical disabilities and have an ongoing system of self–evaluation.

## Decision #9

### *"RETRAIN?"*

#### Description of Decision

The case manager, together with the injured worker, must decide, in consultation with knowledgeable persons whether retraining will make placement possible. The nature and extent of retraining must reflect a willingness to assist the injured worker to the maximum possible extent.

#### Input for Decision

- from Employment Resources
- from knowledgeable people
- availability of training facilities

#### Criteria for Decision

- The injured worker is willing and able to work but has inadequate training for appropriate occupation or profession
- willingness of injured worker to undergo training
- possibility of eventual placement
- knowledge of available training facilities

#### Outcomes of Decision

**Yes**

- purchase of assessment for training services
- purchase of training
- monitoring of appropriateness of purchased services

**No**

- referral to Decision #10

### *PURCHASE OF SERVICE F*

#### Retraining

The case manager, in partnership with the injured worker, and with information from vocational assessment and other input, will help the injured worker enrol in appropriate retraining facilities. The purchase will depend on the appropriateness of the program and the quality of services rendered by the facility.

Where English as a Second Language is advised, it shall be included in the training program.

The level of training selected should not necessarily be the quickest or cheapest available, but shall take into consideration the aspirations and vocational expectations of the injured worker.

## Decision #10

### *"RELOCATE?"*

**Description of Decision**

The case manager, together with the injured worker, must decide, in consultation with knowledgeable persons, whether relocation will make placement possible.

**Input for Decision**

- from Employment Resources
- from knowledgeable people

**Criteria for Decision**

- the injured worker is employable but there are no jobs within commuting distance
- willingness of injured worker to relocate
- availability of appropriate jobs elsewhere
- possibility of placement

**Outcomes of decision**

**Yes**

- client is helped to move

**No**

- referral to Decision #11

### *PURCHASE OF SERVICE F*

**Relocate**

The case manager, in partnership with the injured worker and the injured worker's family, will investigate the possibility of relocating the family in another community.

Costs of relocation will be borne by the Workers' Compensation and Rehabilitation Board and the family will be monitored for a year following the move for reassurance that the move was successful.

## Decision #11

### *"EMPLOYABLE?"*

**Description of Decision**

Following rehabilitation services, the case manager, together with the injured worker, and on the advice of all the people who have contributed to the rehabilitation process, must make a decision on employability. This decision is a weighty one and may be the final one before placement.

**Input for Decision**

- from Employment Resources
- from all other sources of information

**Criteria for Decision**

- all avenues for rehabilitation that can contribute have been utilized

**Outcomes of Decision**

**Yes**

- the client is referred to the placement officer

**No**

- The client is referred to the financial counsellor
- decision on pension and other services follow

**Appendix G**

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## APPENDIX H

# Dissentions

## Recommendation 17

My dissent from Recommendation 17 is based on my firm belief that there should be no discrimination shown in companies with collective agreements. Specifically, I disagree with the final wording of this recommendation "respecting seniority rights".

The employer, the employee and organized labour have a shared responsibility to reinstate the injured worker. We should not absolve organized labour from this responsibility simply because it conflicts with seniority principles. Returning the injured worker is paramount.

Organized labour is not credible calling for reinstatement rights to be superceded by seniority.

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August 17, 1987